IN THE UNITED STATES DISTRICT COURT
FOR THE STATE OF NEW JERSEY
DOCKET NO. 83-2864SA

ANTONIO CIPOLLONE, Individually and as Executor of the Estate of ROSE D. CIPOLLONE,
Plaintiff

vs.

LIGGETT GROUP, INC., a Delaware Corporation, PHILIP MORRIS, INC., a Virginia Corporation, and LOEW'S THEATRES, INC., a New York Corporation,
Defendants

DEPOSITION UPON ORAL EXAMINATION OF SAUL SHIFFMAN, Ph.D. (VOLUME I)

T R A N S C R I P T of the stenographic notes of DIANA L. R. SENATORE, a Notary Public and Certified Shorthand Reporter of the State of New Jersey, taken at the offices of WILENTZ, GOLDMAN & SPITZER, P.C., 90 Woodbridge Center Drive, Woodbridge, New Jersey, on Thursday, March 7, 1991, commencing at approximately 10:00 in the forenoon.

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I N D E X

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SAUL MARK SHIFFMAN, Ph.D.
residing at [DELETED]
having
been duly sworn, testifies as follows:

DIRECT EXAMINATION BY MR. KEARNEY:

Q Dr. Shiffman, my name is James Kearney and I represent Liggett, one of the defendants in this case.

Have you ever been deposed before?

A No.

Q I assume that Mr. Darnell or some other lawyer told you what the process was at a deposition?

A Yes.

Q What did he tell you?

A That you would ask questions and that I was to consider them carefully and answer them.

Q All right. That's exactly what I'm going to do. And I would ask you to consider them carefully and answer them.

A Okay.

Q If you don't understand a question, I would ask you to tell me that and I would attempt to resolve the misunderstanding.

A Okay.

Q Therefore, if you answer a question I

assume that you understand it.

A Right.

Q At any time that you want to take a break, you can do that.

A All right.

Q Can you briefly describe your educational background for us?

A Yes. I have a bachelor's degree from Brooklyn College, City of New York. City University of New York.

I have master's degree and Ph.D. degree from UCLA.

Those are my formal degrees. I can, if you'd like, describe some of the educational experience.

Q Did you have any specialty or concentration, special concentration in your master's and/or doctoral work?

A Yes.

Q What was that?

A They are dual.

I'm a clinical psychologist and also I specialized in psychopharmacology, and in particular in the study of cigarette smoking.

Q Did you specialize in the study of

cigarette smoking when you were in school?

A In the sense that I did research on it, yes.

Q What research did you do on it when you were in school?

A I did -- well, let me see if I can enumerate it all.

I did research on the tobacco withdrawal syndrome as my master's thesis.

I did research on some of the physiological effects of nicotine such as those related to the production of tremor, those related to the effects on the gastrointestinal system.

I did research on drugs related to the opiates also in relation to their physiological effects.

I did research on cigarette smoking relapse.

I'm not sure that's an exhaustive list.

Q This is while you were in graduate school?

A While I was at UCLA, yes.

Not necessarily -- to make it clear, it was not necessarily as part of my -- not in a role as a student. For much of that time I also was functioning as the director of a research program in

the department of psychiatry.

Q Did you do a dissertation?

A Yes, I did.

Q What was the dissertation?

A The dissertation was on -- not on smoking or addiction, but rather on the training of psychotherapists. So it was more in the traditional mainstream of clinical psychology.

Q Do you still have a copy of your master's thesis?

A I'm sure I do, yes.

Q Was it published?

A Yes. It appeared as an article by Shiffman and Jarvik in 1976.

Q Is that listed on your bibliography?

A Yes.

Q Are you a licensed psychologist?

A My license is currently, I don't know what you call it, dormant, because my clinical activities are all channeled through the university and, therefore, in the State of Pennsylvania I'm permitted to function as a psychologist in that capacity.

Q Have you ever been a licensed psychologist?

A Yes.

Q Where?
A In the State of Florida.
Q For how long?
A I don't recall. I'd have to look.
It would have just been a few years since I only spent a few years in Florida.
Q When did you leave Florida?
A 1984.
Q So since 1984 you have not been a licensed clinical psychologist?
A Again, since 1984 I've had my license in suspension but I'm permitted to function as a clinical psychologist through the university.
Q What do you mean by that, you're permitted to function as a clinical psychologist through the university?
A I mean that all of the kinds of activities that the law permits for a clinical psychologist I'm permitted to do, such as seeing patients, performing treatment, et cetera.
Q But you must do that under the tutelage of the university or under the supervision?
A Tutelage would be inaccurate.
In fact, I am the supervisor and the tutor.

Q Okay.
A It's an institutional auspices.
Q All right.
Tell us about your employment since you left UCLA.
A Okay. I was employed as a faculty member in the department of psychology at the University of South Florida.
During some of that time I also had an appointment in the department of psychiatry and behavioral medicine in the School of Medicine.
In 1984 I left there, came to the University of Pittsburgh where I was employed as, initially as an assistant professor.
I was then promoted and tenured as an associate professor, and I'm about to be promoted to a full professor.
Q I want to go back a minute.
You mentioned that you did work in connection with some research institute at UCLA while you were getting your doctorate there. How long were you at UCLA?
A I was at UCLA from 1973 to 1981.
Q And can you describe your professional activities during that time?

A Certainly.

Q And educational activities.

A Yes. I began -- I began as a child, but no -- I began with employment as a research associate in the department of psychiatry to work on -- in the psychopharmacology unit that was studying nicotine and smoking. That employment continued, with some interruptions, for my entire stay there.

To make things clear, there are two parallel tracks here. One is employment in the department of psychiatry which resides in the school of medicine, and also at the Veterans Administration Hospital psychopharmacology unit. In parallel with that was my formal student training in the department of psychology at UCLA.

So that may help clarify some confusion.

So when I came out, I came out not as a student, but as a research associate at the psychopharmacology unit which was associated with the department of psychiatry, School of Medicine, and also with the psychopharmacology unit at the Veterans Administration Hospital Brentwood.

In the fall of 1973 I entered the clinical psychology graduate program at UCLA. I believe my master's degree was awarded about a year

later.

Q Uh-huh.

A During -- during that time, in terms of my research on addiction and smoking I participated in a number of projects and was being promoted within the ranks. I don't recall exactly when those promotions took place.

In -- I don't remember the years -- in 1977 I believe it was, I was awarded a research grant by the National Institute on Drug Abuse to study smoking relapse. So I was the coprincipal investigator on that.

Q Who was the other investigator?

A Murray Jarvik. Murray Jarvik was the chief of the psychopharmacology unit I have described.

During that time I also participated in the drafting of other grants related to the study of drug use and addiction.

I'm trying to think what else is relevant. Maybe you can clarify the question.

Q What was the grant, the one you got in 1977?

A I don't recall the title of it. I can -- the work was concerned with the problem of understanding relapse after people quit smoking.

It was initially directed at testing some treatments for that, but evolved into more of a study of its causes and correlates.

Q And were the results of that research published?

A Yes. There have been quite a few publications. Again, I don't think I could list them all.

If you have a copy of my CV I can identify them, but there are probably a dozen.

Q And they are all on your CV?

A I would think so, yeah.

Q All right. Did you teach any courses at UCLA?

A Yes.

Q What courses?

A I'm not sure I'm going to be able to recall them all, but I taught a course in abnormal psychology. I taught a course in the psychology of sex roles. I assisted in teaching a course on research methods and statistical analysis.

That's all I recall, but I'm not sure that's all I taught. It was quite some time ago.

Q Then you moved on to the University of South Florida; is that right?

A Correct.

Q What was your role when you first got there? What was your position?

A I was an assistant professor. And in that capacity I continued to perform research, taught courses at both the graduate and the undergraduate level, and also supervised the clinical work of clinical graduate students.

Q What research did you do while you were at the University of South Florida?

A Part of it was a continuation of my research on smoking relapse. It took quite some time to analyze the data. So although all the data had been collected, I continued to analyze some of it there.

I also initiated research on how -- on problem drinking among college students and how college students try to cope with that.

Q Who funded that research?

A That was funded internally by the university.

Q What other research?

A I'm trying to think.

Oh, I was involved in a program of research trying to understand eating disorders such as anorexia or bulimia. That was in the department of psychiatry.

Q Who funded that?

A Since I was not the principal investigator I'm not actually sure. It came from --

Q I'm sorry?

A Pauline Powers --

MR. DARNELL: Mr. Kearney, please don't interrupt the witness as this has been happening. He's talking, you're talking.

The court reporter is going to have a problem.

Q Could you spell the name of that principal investigator?

A Powers, P-o-w-e-r-s.

Q And you were involved in that research? What kind of involvement did you have?

A I'm going to stand if you don't mind. It will help me think better.

I was involved in helping her design the research, think about how to perform the assessments of these patients. I interviewed patients with her. I helped her design a data management system. I reviewed manuscripts that she was working on.

Again, there may be -- to be frank, you're asking me about activities of some years ago and there may be other activities I'm forgetting, but that I think captures the gist of it.

Q Where is she located right now?
A I believe she's at the University of South Florida.
Q What courses did you teach at the University of South Florida?
A I taught -- again, I'll have to recall.

I taught abnormal psychology. I taught introduction to clinical psychology. I taught a graduate course on research methods. I taught a course on clinical psychology, an introduction to the clinical treatment, psychotherapy.

Again, I couldn't tell you that that was a complete list.

Q Okay. Then you moved on to the University of Pittsburgh; is that right?
A Right.
Q And that was in 1984?
A Correct.
Q And can you describe what your position was when you arrived there?
A Yes. I had -- I was appointed as an assistant professor. Again, my duties included the peformance of research.

They also included the supervision -- I should mention -- at South Florida, too, going back,

one of my duties was to oversee the clinical training of graduate students who were being trained to be clinical psychologists and psychotherapists.

So supervision involved teaching them how to perform treatment, reviewing their treatment plans, actually reviewing videotapes of treatment sessions. In other words, very direct supervision of their clinical work.

Similarly at the University of Pittsburgh the supervision of clinical graduate students, including a review of their treatment sessions, treatment plans, et cetera, was part of my duties and still is.

Sometime after I arrived, I think it may be two years after I arrived, I was also appointed to be the director of our training clinic.

As part of our training of clinical psychology graduate students, we operate a psychology, clinical psychology clinic that treats people from the community. And it's purpose is to train students in psychological treatment.

In addition to supervising them as a faculty supervisor, I then became director of the clinic, which involved both administrative oversight and additional duties in the training of those

students.

I -- in effect, I supervised the supervisors of those students, handled emergency cases, handled questions of who was appropriate for treatment in the clinic, ran the clinic.

My teaching duties were primarily focused on graduate teaching. As I've described to you, this kind of clinical teaching.

I also taught and continue to teach the introductory -- the major course on treatment methods and also a course on the process of -- of treatment. A big part of my duties in teaching do not involve formal courses that appear on people's transcripts, but rather very close supervision of graduate students who work with me.

In fact, I would say that is the major part of my teaching duties.

Q Any other formal courses that you teach or have taught in the last five years at the University of Pittsburgh?

A I taught -- I also taught introduction to clinical psychology for undergraduates.

And I have taught actually at the University of Washington as a visiting faculty member, a course on theories of addiction.

Q Is that the only course, formal course you've taught on addiction?

MR. DARNELL: Excuse me before you answer that.

When you say "formal course," do you mean where that was the title of the course or the course may have not had it as its title but it may have been one of the curricular subjects?

Which are you referring to, Mr. Kearney?

Q Is that the only course that you have taught in the theories of addiction, Doctor?

A I'm still unsure whether you mean courses that have that in the title or courses in which that was part of the content.

Q Okay. Give me a list of courses that you taught that had that in the title.

A You have that. That is the only one that has it in the title.

Q That wasn't unclear to you, was it, Doctor?

A Sure it was.

MR. KEARNEY: Let's go off the record for a minute, if we can.

(Discussion off the record.)

MR. KEARNEY: Let's go ahead.

Q Now, you gave me the names of all the courses that you've taught in which the theories of addiction were a component of the --

A Let me go back.

Q Let me finish the question, please.

-- of the course.

A Sorry. Let me again explain that much of my teaching is not embodied in courses.

Q You already explained that and I tried to formulate a question that was designed to take your explanation into account and to drop those --

A Okay.

Q Drop that type of activity out.

A That is much clearer to me then.

Q And concentrate on courses where there is a student body standing in front of you.

A Correct.

Q When you give a course it usually involves people coming into a room at a bell.

A Right.

Q It involves you talking in front of them or giving out materials, and when the bells rings they leave. That's what I am talking about.

A Right. And you want to know?

Q What kind of courses like that,

Dr. Shiffman, have you taught in which you have taught about the theories of addiction?

A So you're not asking about the title of the course, but the content?

Q Yes.

A Okay. That would include theories of addiction, abnormal psychology, introduction to clinical psychology and processes of psychotherapy.

Q Okay.

A I should add that another kind of classroom teaching that I do that fits your description is teaching in which there's -- in which I come in and don't teach the whole course, but teach just one or more lectures as a guest expert or specialist.

And I'm quite often asked to do that for courses, to talk about addiction and particularly cigarette smoking.

Q You do that on a regular basis?

A Yes. It's by invitation so I couldn't -- it's not like I do it once a semester. I might sometimes do it many times and I might go a semester without.

Q Okay. So we'll call them addiction lectures.

A Right.

Q All right. So that when I refer to them

again you'll know what I mean.
A Okay.
Q All right?
A Sure.
Q Now, tell me what texts do you use in your introduction to clinical psychology course?
A I'm not sure I'm gonna be able to give you an accurate recall.
I believe -- I have used a text, I believe it's by Goldberg, but let me be clear that I'm not sure, on the Introduction to Clinical Psychology. I believe that's the title.
And we're talking now, to be clear, about the undergraduate course on introduction to clinical psychology.
Q And you think it's a book -- when was the last time you taught that course?
A Would have been about probably '85.
Q All right. And your best recollection is that it was a book by Goldberg?
A Yes.
Q Tell me what book do you use or books do you use in your theories of addiction course?
A I didn't use a single book. It was really quite -- because that was an advanced graduate course

that included people ranging up to post doctoral fellows and senior faculty. The readings were quite diverse and they were collections of articles, chapters from books. There was no one single text.

Q Did you -- was that a course that you gave to the students for credit in some respects?

A Yes. Uh-huh.

Q And that was given under the auspices of the University of Pittsburgh?

A University of Washington.

Q University of Washington?

A Yes.

Q When were you there?

A I was there this last spring. Spring of 1990.

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Q You were there for one semester?

A Correct.

Q Can you just tell me what, if you can recall, tell me what articles form the basis of this course, or what articles did you use in teaching that course?

A There were so many I genuinely could not begin to recall them.

Quite literally the reading would probably be three-quarters of a foot high.

Q All right. What book did you use in your

abnormal psychology course in the last five years?
A I have used several.
The one I most recently recall is by Coleman and other authors. Coleman is the first author. There's some others whose names I don't recall as well.
I think it's Coleman, Butcher and Beutler. Something like that. But it's called "Abnormal Psychology."
Q And you talked about a course. I don't know if I got it down right, processes of --
A Psychotherapy.
Q -- psychotherapy, I think.
A Correct. Again.
Q What text do you use in that course?
A Again, it's quite typical of advanced graduate courses that I would not select a single text but a collection of readings. And, again, the readings are so extensive that I could not begin to recall.
Q Do you view that there is one or two authorities on the subject of the processes of psychotherapy?
A Actually, I think there are many authorities.
Q All right. Are there any leading authorities or primary authorities?

A I -- in all honesty -- in all honesty, I'm not sure what you mean by an authority because that's not the way academics --

Q Let's do it this way: Do you recall any books that you referred to your students, referred your students to in that course?

A In fact, I don't. Because, again, the readings tend not to be whole books, they tend to be articles on a particular point.

Q Now, in these addiction lectures --

A Uh-huh.

Q -- do you refer your students in those lectures to any authorities?

A I give them readings, if that's what you mean.

Q Yup. That's what I mean.

Can you tell us what readings you give them?

A It would depend. It's very variable. It would depend very heavily on what -- what the class was -- what I saw as the central theme of the lecture.

Very often I would assign them to read some of my own writings. That would be quite typical.

Q Okay. If the course was relating to addiction and cigarette smoking, do you know of any writings that you would refer those students to?

A Yes. Yes.

Q Other than your own writings?

A I often use the Surgeon General's report as a source.

Q That's the Surgeon General's record entitled, "Nicotine Addiction"?

A Addiction.

Q Labeled 1988?

A Right. And I have also used, the 1979 report has a lot of relevant text.

Q Anything else?

A Again, there are -- there may be a lot of other articles that I assign but --

Q But you can't recall any of them now, any of the authors?

A There are just too many, sir.

Q Okay. Who do you recognize, sir, as an expert in the field of addiction?

A I would see Jack Henningfield as an expert. Jerome Jaffe is recognized as an expert. Michael Russell.

I'd say those are the primary experts.

Q Would you consider Neil Benowitz an expert?

A Yes. On the pharmacology specifically. Again,

expertise is usually rather specific.

Q What is your specific expertise?

A My expertise is rather broader than most, so my expertise is on biobehavioral models of addiction. That is, I try to integrate both biological and behavioral factors independent and addiction.

Q Whereas you say Benowitz is --

A And I further focus on the treatment of addictions.

Q Would you recognize any other person other than yourself as -- and if so, can you tell me the name of the person -- as an expert in the biobehavioral models of addiction?

A I guess I'm not -- I can't think of anyone.

Q So as far as you know, right now you are the most expert person in the entire world and there is no other expert that you even recognize in the entire world on the subject of the biobehavioral models of addiction; is that your opinion?

A Are you asking whether the particular balance of expertise and background is unique or -- like I said, I'm not clear.

Q I'm asking you this: Is it your opinion that you are the only person you recognize as an expert in the area of biobehavioral models of

addiction?
A No.
Q Name the others.
A I think Michael Russell would be one, as I mentioned. Jack Henningfield would be another. Ovid Pomerleau is.
Q Anybody else?
A Again, I couldn't -- no one comes to mind.
Q That's --
A That's not to say --
Q John Hughes?
A His expertise is rather different.
Q Do you recognize that he's got expertise in this area at all?
A Which is this area?
Q In the area of addiction.
A Yes. He does have expertise in that area.
Q What would be, in your opinion, his expertise in the area of addiction?
A Primarily behavioral pharmacology.
Q What is the difference between biobehavioral models and behavioral pharmacology?
A Behavioral pharmacology is a much more narrow discipline arising out of animal -- experiments with animals on the response to drugs.

Some of those methods also get applied to humans, but it's not the same as taking into account broader behavioral principles.

Q Why is it not the same? Explain to us why it's not the same.

A A behavioral pharmacologist would tend to restrict himself to a few paradigms or ways of approaching a problem that don't take into account many aspects of behavior such as effect or cognition.

Again, in effect the field methodologically treats, whether it be people or animals, in much the same way and that --

Q And that doesn't work?

A I'm not saying it doesn't work. I'm saying it's a narrow viewpoint.

Q Because animals are different from men, humans?

A In some respects.

Q In respect to effect and cognition, among others; correct?

A I would say that human beings have more complicated cognitions.

Q It's a different biological system?

A No, no. On the contrary.

With regard to some of the biological

aspects our similarities are stronger.

Q What about -- have you heard -- ever heard of Lynn Kozlowski?

A Yes.

Q Do you consider him in any respects an expert in the field of addiction and cigarette smoking behavior?

A No, I don't.

Q Excuse me?

A No, I don't.

Q What is his -- you said you are familiar with his name. Is he an expert in any field?

A I've met him. I have read some of the things he has published. I don't consider him an expert.

Q Do you disagree with things he has published?

A I cannot even claim to have read everything he's published, so it's hard to say.

I disagree with some -- mostly I don't find them very important.

Q Why is it that you would not consider him -- well, let me withdraw that.

You have read some things Kozlowski has written?

A Correct.

Q Do I assume correctly that you don't agree with some of the things you have read that he has written?

A To be frank, that's not the basis -- that may be true. I would have to think about that.

That's not the basis for my suggesting he is not an expert.

Q Okay. Could you explain for us the basis for you suggesting that he's not an expert?

A Yes. My -- from what I have read of what he's written, it doesn't seem to me to be very relevant or important. And I don't -- I don't see him as having made a major contribution to the area.

Q Other than the Surgeon General's report labeled "Nicotine Addiction," are there any other authoritative works on addiction and smoking behavior that you are aware of?

A Can you explain to me again your idea of what an authoritative work is?

Q Have you ever heard the term "authoritative work" used in your professional experiences?

A It just isn't how, how people talk about each other's work so --

Q But you've heard it before?

A I've actually heard it, read it more in depositions than I have heard it in academic contexts.

So I really -- I want to be responsive. I want to be sure that I'm responding to what you mean and not to some other version.

Q Absolutely fair.

Authoritative work, by that I mean a work on which professionals in your field customarily would rely upon in the course of the conduct of their professional activities. That could include clinical work, research and teaching.

A And rely upon means consult?

Q Yes.

A Agree with?

Q That they would consult.

A Okay. And you understand that in my field one might consult things one doesn't agree with.

Q We'll get to that next.

A Okay. In fact, it's our job not to agree with things.

Q It's my job, too.

A Let's see. I would say perhaps it would be helpful if I said there are particular journals that are more respected than others.

Q No. I'm looking now for texts. Texts

that are respected as authoritative sources in the field of addiction and smoking behavior.

A Uh-huh.

Q Other than the Surgeon General's report.

A Right. I just can't think of any that I would want to endorse in that way, because they're often of quite mixed quality.

Q Would you say there are a lot of different views about the nature of this phenomenon which I understand you call cigarette smoking addiction or dependence?

A There are -- there's actually a pretty good consensus regarding it at the moment in the scientific community.

Q There isn't very much controversy about it in your view?

A There's some. I would say quite minor.

Q But notwithstanding that, you can't tell us any text that you would consider to be authoritative on addiction and cigarette smoking behavior?

A Well, I've given you a couple but it's just not the way I think of things. I'm just --

Q Okay. Let's talk a little about your research.

You mention that when you moved to the University of South Florida you continued to analyze data on your relapse research?

A Correct.

Q Can you describe the relapse research and the data that you are analyzing at the University of South Florida?

A Certainly.

***** MR. KEARNEY: Off the record.

(Discussion off the record.)

(Recess.)

(Notes of R. Cipollone's trial made by Dr. Shiffman are received and marked as Exhibit Shiffman-1 for Identification.)

(Notes of R. Cipollone's relatives' depositions made by Dr. Shiffman are received and marked as Exhibit Shiffman-2 for Identification.)

(Notes of R. Cipollone's deposition made by Dr. Shiffman are received and marked as Exhibit Shiffman-3 for Identification.)

(Notes of the deposition of Dr. Jaffe made by Dr. Shiffman are received and marked as Exhibit Shiffman-4 for Identification.)

(Document entitled "ICD-9 WHO 1978," made by Dr. Shiffman is received and marked as Exhibit

Shiffman-5 for Identification.)

(Notes of Surgeon General's report made by Dr. Shiffman are received and marked as Exhibit Shiffman-6 for Identification.)

(Document entitled "Strategic Summary of Tobacco Company Documents," made by Dr. Shiffman is received and marked as Exhibit Shiffman-7 for Identification.)

(Document entitled "Addiction" is received and marked as Exhibit Shiffman-8 for Identification.)

(Letter dated 3/4/91, Darnell to Kearney with attached CV of Saul Shiffman received and marked as Defendant's Exhibit Shiffman-9 for Identification.)

MR. KEARNEY: Can we have that last question read back?

(Question read back as follows: "Can you describe the relapse research and the data that you are analyzing at the University of South Florida?")

BY MR. KEARNEY:

Q Okay. I'm going to -- Dr. Shiffman, with respect to your clinical practice today --

A You don't want me to answer that question?

Q No.

A Okay.

Q You did answer it. You said certainly.
With respect to your clinical practice today, am I correct that you see no private patients --
A That is correct.
Q -- that are patients just of yours that you bill?
A That is correct. I supervise the treatment of patients through students and through supervision of trainers and people who provide treatment both for general clinical problems as well as for smoking related problems.
Q Do you have any administrative responsibilities?
A Yes, I do.
Q Could you describe your administrative responsibilities?
A As I say, in relation to the clinic, I am the administrator for the clinic, so that means arranging for other faculty supervisors; setting policies for them; arranging for students to be assigned to cases; deciding what kinds of cases we will accept; arranging for the evaluation of students' performance; arranging for the evaluation of supervisors' performance; assigning grades; you know, making sure records are --

clinical records are kept up to date. That's in relation to the clinic.

In relation to my own research program administering bu -- research grant budgets; supervising personnel; arranging for the orderly function of our office; hiring and evaluating employees; arranging for data management; getting us appropriate space in facilities, et cetera.

And then in relation to -- I have some administrative responsibilities in relation to a smoking cessation program that is administered now primarily by The American Cancer Society, but was initially a joint project between the University of Pittsburgh and The American Cancer Society.

Q And what are your administrative responsibilities in connection with the smoking cessation program?

A Again, administratively I set broad policies regarding the selection and training of personnel to administer treatment; I think about how to keep our records; I may serve as a liaison with The American Cancer Society to smooth relationships between the two institutions.

I'm sure there are things I'm not thinking of but that --

Q And you had been -- the smoking cessation program has been in existence since when, sir?
A May I consult my resume because --
Q Sure.
A It's been going on so long. It seems like forever.
I don't have a copy here.
MR. DARNELL: Do you have a copy with you?
MR. KEARNEY: I may have a copy with me. Well, I'm -- we can do that during the break if you like.
Q You can't answer that question, though, without consulting your CV?
A I basically don't want to give an inaccurate answer.
Q I agree, and I don't want an inaccurate answer.
A I would say it's several years.
Q Several years. That's fine.
And you have had those administrative responsibilities since the program began?
A As a matter of fact, I created the program, yes.
Q The answer is yes?

A Yes.

Q And how long have you had the administrative responsibilities that you talked to us about in connection with your research program? How long have you been doing that?

A Since I came to the University of Pittburgh.

Q 1984?

A Correct.

Q And you described some administrative responsibilities that you had for the psychology clinic --

A Right.

Q -- at the University of Pittsburgh?

A Right.

Q And you've had those responsibilities since 1984?

A No. I believe that was since 1986. But, again, it's -- it's a long time.

Q All right. About how much of your time since 1986 is spent in the administrative functions that you've just discussed in those three areas; the psychology clinic, the research program and the smoking cessation program?

A That would be very hard to say for two reasons. One is that it is enormously variable.

So for example, at the beginning and end of semesters my duties as clinic director become more pressing and more demanding.

The other is that while I've described things to you as administrative functions in all of those roles, they are rather integrated with clinical and teaching functions.

And so if you're -- well, maybe I should ask whether the focus of your question means to distinguish administrative from research and clinical and teaching functions?

Q It does.

A Okay. As I say, it's very variable.

Q In a year can you give us an estimate?

A I'll try to do it for you in a week or a month.

Purely administrative it hovers around four hours a week, if I tried to separate out teaching clinical and research functions.

Q Is there anyone in the clinical psychology area at the University of Pittsburgh who has a license from the State of Pennsylvania to practice clinical psychology?

A There are some, yes.

Q Is that a requirement of the university that they've got some license as psychologists?

A No, it's not. And, in fact, several faculty don't have -- haven't activated Pennsylvania licenses for the same reason.

Let me just make something clear so that it is clear to you. I've met all the requirements for licensure in Pennsylvania. I simply haven't filed the paperwork because it hasn't -- it doesn't produce any advantage for me so long as my clinical activities are in the context of my university employment.

Q Do you today have primary care responsibility for any patients?

A I don't know what you mean by primary.

Q You're their doctor.

A Yes.

Q How many?

A I'm responsible for all the patients in the clinic, which is -- varies, but let's say 20.

Q Twenty?

A Yeah.

Q And that number of patients, although it varies somewhat, it's pretty much 20 -- how do I put this?

At any given time the clinic is serving approximately 20 patients; is that right?

A It varies -- yes.

And, again, to make that clear, I have responsibility because I'm clinic director. I may not necessarily meet these patients. I may never meet them. They may come and be treated and be cured, and go off to live happily ever after and I will never meet them.

I have the primary responsibility in the sense, for example, that if an emergency occurs I'm gonna be -- I'm the person who is likely to be called in to attend to it and so on.

Q I guess then I asked the wrong question.

I'm asking this question: Today how many patients look to you, sir, as being their, their doctor to diagnose them, to treat them, to take care of them?

A Come and meet with me and so on, is that the question?

Q My question was, how many view you as their doctor?

A I'm not sure I can say who views me as their doctor.

Q Have you ever treated anybody for heroin abuse?

A No.

Q Have you ever treated anybody for cocaine

abuse?

A No.

Q Have you ever treated anybody for abuse of marijuana?

A Yes.

Q Have you ever treated anybody for alcoholism or alcohol abuse?

A I have treated, yes. I've treated patients in whom that was a problem.

Q Were those patients people that came to you, Doctor, for treatment for alcoholism?

A I'd say they were being treated for alcoholism.

Q I beg your pardon. I didn't catch the beginning of that answer.

A Let's say they were being treated for alcoholism.

Q Was that their primary complaint?

A Are you asking what they thought their problem was or what the medical and psychological care givers staff thought was a problem?

Q Let's do the latter.

A Okay. They were being treated for alcohol problems because the staff thought that that was a problem for them.

Q All right. But we're now talking about

people whom you have treated?
A Correct.
Q Have you treated anybody for abuse of amphetamines?
A No. I believe not.
Q Have you treated anybody for abuse of barbiturates?
A I believe not.
Q In what setting did you have occasion to treat people for or a patient for marijuana abuse?
A It would have been at the -- actually the one I remember is at the Veterans Administration Hospital.
Q And that was when you were in Los Angeles?
A Correct.
Q And that would have been -- you left L.A. in 1981; correct?
A Correct.
Q So it would be sometime prior to 1981?
A Correct.
Q How many people did you treat for marijuana abuse?
A I believe there were three in a --
Q And that was before you became a licensed psychologist?

A Correct.

Q Licensed to practice psychology?

A Correct.

Q And, therefore, I assume you did that under the supervision of some licensed psychologist?

A Right.

Q What was his name?

A As part of my training.

Q What was his name or her name?

A I don't recall who my supervisor was.

I've had literally dozens of supervisors so I -- I couldn't tell you which supervisor was in charge of those cases.

Q Now, were these people that came to you as -- with the primary complaint that they were marijuana abusers?

A They often came in because of other complaints, but as I explained, it was judged by the professional staff that marijuana abuse was either contributory or may even have been a major problem for them.

Q And they were treated for marijuana abuse?

A Correct.

Q And they were diagnosed and treated by the professional staff?

By that I mean not you singularly, but you along with the professional staff who were training you at the time to become a psychologist?

A What do you mean by me singularly?

Q By that I mean that you cared for these people in conjunction with those folks at UCLA who were training you to become a psychologist. You didn't do it alone.

A That's right.

Q You mention that you treated people for alcoholism. In what context or setting was that, sir?

A That would have been in two contexts.

One, again at the V.A., and the other when I was in private practice in Tampa, Florida.

Q Now, when you say "again at the V.A.," that's in L.A. before 1981?

A Correct. Uh-huh.

Q And it was before you became a licensed psychologist?

A Uh-huh.

Q And it was in connection with your training to become a psychologist?

A Uh-huh.

Q And how many were there, sir?

A I'd say at least half a dozen. I can't

remember them.

Q And who was your supervisor, or was the licensed psychologist who worked with you in treating these people?

A Again, I had so many that I couldn't accurately -- I don't think that I could accurately even list all my supervisors, much less tell you which ones were involved in these cases.

Q Can you name one supervisor that you had in this period of time?

A Let me think.

Q By this period of time I mean when you treated these half dozen people for alcoholism.

A I think her name was Evelyn Crumpton.

Q Could you spell that?

A C-r-u-m-p-t-o-n. I hope I've got that right.

Q And she was a licensed psychologist?

A Correct.

Q And she practiced in the L.A. area?

A She was at the Veterans Administration Hospital.

Q Have you had any contact with her recently?

A No.

Q Do you know if she's still there?

A I have no idea.
Q Can you name anybody else?
A It really fades into memory, and I don't want to give you an inaccurate response.
Q We do not want inaccurate responses, neither Mr. Darnell nor I. We don't want you to speculate.
You mention that you treated -- withdrawn.
I must have missed your private practice in Tampa. Can you tell me, when did you start your private practice in Tampa?
A It was soon after I arrived. Let me see.
I would estimate within a year of my arrival.
Q So that would be 1985 approximately?
A Correct.
Q And where was your office located?
A In a professional building near the campus.
Q Do you remember the address?
A I don't.
Q Were you practicing on your own or in concert with somebody else?
A In concert with somebody else.
Q Who?

A It's funny. I can see his face and I cannot grasp his name.

Q How long did you practice with him?

A For a couple of years.

But we were not -- that didn't mean that we had all that much interaction.

Some of the arrangement involved my having use of his office so that I didn't have to rent an office and so on. So --

Q Was your name on the door?

A You know, I don't remember.

Q Did you have a telephone number which people could reach you?

A Yes.

Q Was the telephone number listed in your name?

A Yes.

Q How long a period of time did this private practice last?

A Until I left Tampa.

Q Which was when?

A 1984.

Q I think we might have had a little misdirection by me here. So therefore --

A Backwards you had.

Q I had your practice down in '85.
A It was very short. From '85 to '84.
Q From '85 to '84, I don't doubt it.
No. The practice must have been something like '82 to '84, right?
A Right. I'm saying '82 at the latest. I don't really recall.
I said about starting a practice soon as I arrived. When exactly my phone was listed with them, et cetera, I couldn't honestly recall.
Q How much time did you spend in your private practice when you were down in Tampa?
You know what I mean by that? How much of your professional time?
A Yes. It varied. Let's say about four hours a week.
Q Four?
A Uh-huh.
Q Did you share responsibility, patient care responsibility with this gentleman whose name you don't remember, or did you have your own individual patients?
A I'm remembering his name. Saunders, S-a-u-n-d-e-r-s.
Q Is he still, to your knowledge, in the

Tampa area?
A I believe he is, but I don't know. I haven't kept up with him.
Q Was he a full-time clinical psychologist?
A I'm not sure what you mean by that. I'm a full-time --
Q Pardon me?
A I'm a full-time clinical psychologist.
Q I don't know what a full-time clinical psychologist means, I guess.
I thought you said you worked four hours a weekend?
A A clinical psychologist does things other than --
Q Treat people?
A Treat people directly.
Q Were you a member of the American Psychological Association's local chapter in Tampa when you were down there?
A The American Psychological Association doesn't primarily operate by local chapters.
Q Were you a member of the American Psychological Association?
A Yes.
Q Were you a member of any sections of that

group?

A Yes. Which ones I was a member of then, I would have trouble recalling.

Q Okay.

A I can tell you which ones I'm now a member of if that would be helpful.

Division -- they're called divisions. And Division 28 is psychopharmacology and it's my primary affiliation.

Division 38 is the division of health psychology. It's concerned with behaviors that affect health, and that includes cigarette smoking.

I was a member, but I believe have since dropped my membership, in Division 12 which is clinical psychology, and Division 29 which is psychotherapy.

Q Now, was this practice that you had, was it open for two years or was it open -- how many years did you have it open?

A I think I've already told you that I'm not sure exactly when it started. It was two to three years I'd say.

Q Two to three years?

A Yeah.

Q I guess the issue is when in '84 did you

go to Pittsburgh?
A Oh, all this would have happened on a -- on an academic calendar year basis, so it would have been summer to fall of '84 that I left.
And the -- I would have made moves to start my clinical practice soon after arriving in the fall of '81.
Q Okay. So you'd say you were open from '82 to '83 and open half of '84?
A Run that by me again.
Q So you say that your clinical practice was open, you were open for business calendar year '82?
A Uh-huh.
Q Probably the whole part of the --
A I think so but --
Q -- calendar year '83?
A Right.
Q And part of '84?
A That sounds right.
Q Did you share billing --
A No.
Q -- with Dr. Saunders?
A No.
Q You did your billing separately?

A Right.
Q What about patient records? Was that done together?
A Again, no.
Q What about referral of patients?
A He -- actually what I recall is that he told me he intended to refer patients to me, but that never really materialized.
Q What was his first name?
A Alan. A nice name.
Q Okay. Now tell me -- you mention that you treated patients for alcoholism in connection with this practice.
How many?
A I believe in that practice it was one.
Q For how long did you treat that person?
A I don't honestly recall.
Q Was that person's primary complaint alcoholism?
A Can you clarify what you mean by primary complaint? Because that is not a simple concept.
Q All right. When that person presented themselves to you or himself or herself to you, did she say that her complaint -- did she say to you that I'm drinking too much?

A I'm gonna back up again and say that it's -- it's common and indeed expected that what a professional considers is a primary complaint isn't what the patient comes in and presents with.

So if the patient comes in and has all sorts of other problems and it is very clear that they're due to the person's problem drinking, then I would consider that to be the primary complaint even though they're not saying that that's what they want help with.

Q Okay. Fine.

So I understand it, with respect to this patient you considered that patient's primary complaint to be alcoholism?

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A I did, yes.

Q Fine. Did you refer that person to a detox program?

A At the time that he came to me he was not drinking enough to warrant that, so I treated him on an outpatient basis.

Q Did you refer that person to Alcoholics Anonymous?

A No.

Q Did you refer that person to any Tampa area alcohol treatment program?

A He had already -- as I recall, and I don't remember the details, I think he had already been in one, but I don't remember for sure. It was a long time ago.

Q Do I get the sense then that he had been treated for alcoholism by -- by somebody else or -- and in some other program?

A I believe that he had but I -- I don't want to get into stating things with any more certainty than I have.

Q Absolutely.

Let me ask you this question: While you were treating him was he also getting treatment for his alcoholism by anybody else or in any other program?

A My recollection is that he was not.

Q How long did you treat him for?

A You asked me and I said that I couldn't recall exactly.

Q Was your treatment successful?

A I believe that it was, yeah.

Q Do you believe that people who are alcoholics can quit, can stop drinking?

A Is it physically possible; is that what you mean?

Q Yes. Is it physically possible?
A Has it been done, yes.
Q It's not impossible to quit the use of alcohol by an alcoholic?
A That is correct.
Q All right.
A Let me make it clear. There are people who have received a diagnosis of alcoholism and have subsequently stopped drinking.
Q What was your primary mode of treatment -- let me go back. I'm sorry.
I have to ask, was your treatment successful of this person?
A I believe that it was. But since -- since a judgment of that requires longer follow-up than I was able to do, I don't think I'm in a position to say.
Q But while you were treating him you considered it a successful cessation from drinking?
A He didn't -- I wouldn't say he completely stopped drinking during the entire time he was in treatment with me.
Q So it wasn't successful?
A No. It was heading toward being successful and, in fact, there were times that he stopped.
Q How did you -- what was your primary

treatment vehicle for this person to get him to stop drinking?

A There were multiple modalities. It included -- I also, as I recall, worked with his wife. So I involved her in his treatment.

We worked on analyzing his patterns of drinking, closely examining his -- the consequences of drinking for him, trying to redesign his life, if you will, to make it less likely that he would drink.

We worked on analyzing his urges and cravings to drink.

Q When you say that -- I don't want to interrupt you and pardon me -- but when you say that you mean you worked on it with him, not with the wife? You discussed with him --

A Correct.

Q -- his urges and cravings?

A Correct.

I wouldn't exclude that I may have had discussed them with her as well.

Q Okay. Is that it?

A Yes.

Q You mention that you have treated abusers of amphetamines. In what context did you do that?

A As I recall, again, that was at the Veterans

Administration Hospital.

Q All right. So again, that was when you were at UCLA in training to become a psychologist and before you were licensed as a psychologist?

A That is correct.

Q And before you got your Ph.D. in psychology?

A That's correct.

Q Had you gotten your master's at that time, at the time you were doing this treatment?

A Yes.

Q How many were there?

A For amphetamines I think it was only one.

Q Do you recall who was your supervisor during that treatment?

A The same answer, it's --

Q Do you recall whether or not you were the only person who saw this patient in treatment, or was there some other human being that saw that person with you?

A I don't recall, but it would -- in terms of treatment at the Veterans Administration, it's very likely he would have been under the care of others as well.

Q Okay. You mention that you treated

people for barbiturate abuse. In what context was that, sir?

A Veterans Administration.

Q And how many?

A You know, I cannot recall.

Q Can you recall whether it was one or more than one?

A It may even have been one, but I can't recall.

Q So you're not really sure whether you treated anybody for barbiturate abuse?

A No, I didn't say that.

I said that it may have been more than one but it was at least one.

Q Okay. I'm sorry. I thought you said it may not have been one.

A No.

Q Okay.

A Less than one patient is hard to treat.

Q Yes.

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When you mentioned you treated one person for barbiturates and one for amphetamines, about a half a dozen for alcohol and three for marijuana in the V.A., were any of these people the same people?

A No.

Q One person had all of these different

complaints?
A No.
Q They're all separate instances of treatment?
A I believe so.
Q Okay.
A Again, by way of context it was some years ago, but I don't believe they were the same.
Q Okay. When you were at the V.A. --
A Uh-huh.
Q -- and working towards your doctorate at UCLA, did you treat anybody for tobacco dependence?
A At the V.A.
Things get complicated here because during the period I was at the V.A. I was at the -- well, let me make it simple; yes.
Q How many?
A I would say about -- this is a round number -- 100.
Q And this is in the period that you were in your doctoral program?
A Yes.
Q Prior to 1981?
A Correct.
Q You treated -- and who supervised you in

the treatment of those people?
A I was, in fact, supervising others in the treatment of those people, most of that time.
Q And this was before you were licensed to practice?
A That's right.
Q And before you got your doctorate, right?
A You ought to know that it is very common for treatment of tobacco dependence to be performed by people with -- who are not licensed as clinical psychologists.
Q Is it common for people to treat alcoholics, for unlicensed psychologists to treat alcoholics?
A In training it's very common and -- as a matter of fact, outside of training it's common.
Q In training they do it with supervision; correct?
A Typically, yeah.
Q Now, I'm a little unclear.
You said that you treated 100 people for tobacco dependency?
A Uh-huh.
Q Prior to 1981?
A Correct.

Q In what context was that treatment given?
A There were multiple contexts.
One context was that we conducted group treatment for people who were both patients and employees of the Veterans Administration who needed treatment for smoking or for nicotine dependence. That was one context.
The second context was our provision of counseling through -- actually there are more than three. Our provision of counseling to and treatment to community people who were trying to stop smoking.
A third context was our provision of treatment and counseling through -- telephone counseling through a counseling service that we offered to the community. So it was telephone counseling.
And then the fourth context was through my supervised -- I was also in fully supervised private practice while in L.A.
Q Is that it?
A I believe so.
Q When you say "supervised private practice," somebody supervised you in your private practice?
A Correct. Because I -- in that context the fact

that I was not yet licensed mattered.

Q Where did you have your private practice in L.A.?

A I don't recall the address. It was Santa Monica Boulevard somewhere.

Q Did you have your own office or did you share an office?

A I shared an office.

Q Who did you share it with?

A I believe his name was Jeffrey Hutter, H-u-t-t-e-r.

Q Where is he located now; do you know?

A I don't, but I would expect he's probably still there.

Q Was he a licensed psychologist?

A Yes.

Q And you were working in his office?

A Correct.

Q And he was supervising you?

A Correct.

Q How long were you doing that for, sir?

A I think that would have been about three years.

Q Three years.

Did you have your own patients or did you just work with him on his patients?

A I had my own patients.

Q You had separate billing and whatnot?

A No. Billing was through him, but they were my patients in the sense that, to use your phrase, they saw me as their doctor. I was -- I met with them, Dr. Hutter did not.

Q Okay. How many people did you treat for tobacco dependence in that context, the supervised private practice with Dr. Hutter?

A I think it was just a couple. It was a small number.

Q Two?

A I'd say two.

Q So these were people who came and paid you for your services to help them stop smoking; is that right?

A That's right.

Q Were you successful?

A Yes.

Q How did you go about doing it?

A Well, it was very intensive. We met at least for an hour a week.

At the time I was using a procedure called rapid smoking, which you may be familiar with. It involves smoking cigarettes as fast as you can till

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they make you sick.

The idea was to make smoking aversive and come to have aversive or unpleasant or punishing connotations.

You know, come to think of it, I think I was not always successful. I'd like to think that I was. And --

Q We're just talking about the two?

A Those two, right. Right.

Q So you were not successful or you were successful?

A I think it's really half and half. It's really hard to remember individual patients.

And as in the treatment of problem drinking, we would have reviewed the circumstances of the person's smoking, their smoking history, their associations with smoking. We would have tried to make changes in their life to make smoking less likely, or to make urges and cravings less likely.

And again, the -- the rapid smoking treatment would have been part of that strategy.

Q When you say "we," you did this by yourself though, right?

A Oh, I was counting the patients as a collaborator if you will.

Q So you say the treatment is the same as the -- that you used for alcoholics?
A There are some similarities, yes.
Q Certainly you don't use rapid drinking procedures for alcoholics, do you?
A Well, as a matter of fact, there are procedures very similar to that that have been used with alcoholics.
Q Really? What are they?
A People give alcoholics drugs which cause either -- drugs which cause them to throw up when they drink.

Electric shock had been used; that is, there are treatments in which people may shock a drinker as he or she is drinking, or they may be given drugs which they take chronically and whose purpose it is to make them sick if they should drink.

Q You've never used those treatments, or have you --
A No, I haven't.
Q -- for a tobacco dependent person?
A Which treatment?
Q The ones you just mentioned.
A Those were treatments for alcoholism.
Q Right. And you say they were similar to

tobacco, so I'm asking you if you ever used them for tobacco.

A The similarity is that the strategy is to make the person sick while they're using the drug and, therefore, to come to have negative, aversive associations with the drug.

Q Right.

A So in some sense, yes, that is the same treatment.

Q But in other senses it's not the same treatment?

A That's right. It doesn't use the same drugs.

Q Right. And you don't use electric shock?

A I haven't, no. Others have.

Q Now, this counseling, telephone and counseling service, could you describe -- and you say you treated tobacco dependent people over the telephone; is that right?

A I'm not sure I would -- well, the word treated is ambiguous here.

Let me describe it to you rather than characterize it.

Q Have you ever treated an alcoholic over the telephone?

A No, but others have.

Q Solely over the telephone?
A I believe that's probably true.
Now, many of these people were also -- had other treatment elsewhere.
Again, if you will let me describe it rather than characterize it I'd be glad to do that.
Q Go ahead. Why don't you do that.
A One of the problems in any treatment, whether for alcoholism or for smoking, is that the treatment stops but the patient's difficulty continues. And we thought it would be a good strategy to make some kind of counseling available by telephone. That way even once the treatment -- the treatment stops in both -- in the sense that the difficulty people have both in drinking and smoking persists for months, the treatment does not; and also in the sense that crises can occur for the person on a weekend and treatment tends to be structured in such a way that it's not available on the weekend.
So our approach was to provide basically hot line crisis counseling to people who are having difficulty in quitting smoking. So that was basically a process.
Q Who is responsible -- who set up that program?

A I did.
Q Did you -- who answered the phones?
A I did, and I also had staff who answered the phones.
Q Where was it located?
A This was in L.A.
Q Who funded it?
A National Institute of Drug Abuse.
Q Who was the major grantee, if you will, of that fund, of that grant application?
A The principal investigator?
Q The principal investigator.
A Was Murray Jarvik.
Q But he didn't supervise you in connection with this counseling telephone service?
A Only very, very broadly pretty much.
Q He would agree with you that you set it up and not he?
A He. I believe that's so.
Q Okay. He did not participate in the telephone service?
A No.
Q All right. How many people did you have working in the telephone service?
A Who were answering the phones directly; is that

what you're asking?

Q Yes.

A There were three other than me I believe.

Q How did you promote the telephone service?

A We -- there were -- there were several methods.

We had notices on the radio. We made it known to people, we had newspaper publicity. We had made announcements in smoking clinics, both ones that we conducted and ones that others conducted.

I think those were the major methods. We were trying to promote it in as many ways as possible really.

Q Wasn't that for people who had already quit and had crises after they quit smoking?

A That's right.

Q It wasn't for smokers that were -- that were continuing to smoke and that hadn't quit, right?

That's the way it was promoted?

A Can you say the question again?

Q It was promoted for people -- to help people who had already quit to stay quit; isn't that the way it was promoted?

A That's right. I don't believe that's how you put it the first time, but that is correct.

Q Okay. Thank you.

And am I correct also that part of the program was to elicit information from them by having them -- in essence, having them call, having callers fill out a questionnaire -- have the counselors rather fill out a questionnaire when they were speaking to these call-in people, right?

A That's correct.

Q So the purpose wasn't solely treatment?

A It was treatment, but not solely treatment. That's correct.

Q Okay. The other three people that did this with you, can you give me their names and their then educational background?

A Certainly. Joan Rauschenberg. I couldn't spell it for you, but I think it's about how it sounds.

Q By their educational background I meant their background at that point in time.

A I understand.

Q Thank you.

A She was a Ph.D. psychologist.

Another person was David Rapkin. He was an advanced graduate student in clinical psychology and he was in practice at that time.

And then Laura Read, who I believe at that time she only had a bachelor's. She's gotten a Ph.D. since, but had extensive training and experience treating smoking and nicotine addiction.

Q How long did that program go on for by the way?

A I'd have to give you a ballpark of about two years, but I wouldn't stake my life on it.

Q Was there one office that that was operated out of?

A Yes and no.

Q Where did you receive the phone calls?

A As I said, yes and no. We had a central office.

In order to facilitate providing the service efficiently we also had an answering service which could route calls to -- to those people providing treatment by beeping them on a beeper.

So there was both -- there was a central office. Many calls were taken there. Evenings and weekends calls might well be taken through an answering service and paging an appropriate treatment person.

Q Okay. What -- and you actually manned the phones for a period of time?

A Correct.

Q How many people did you counsel in this time?

A That is where my recall is going to be very hazy, because there were so many and because initially I was the only counselor. Over time I did less counseling, but I continued to do some.

Q Initially you were the only person answering the phones?

A Correct.

Q Okay. Did you make a record of the people that called?

A Uh-huh.

Q Did you take their name and telephone number?

A Not necessarily, because when people called a hot line usually they expect anonymity, and we provided them that and most of the time we didn't get a name and a phone number.

Q So therefore, you treated these people for tobacco dependence in one phone call; correct?

A We -- well, firstly there were quite a few people with whom we had more than one contact, and I wouldn't characterize it as our providing a complete treatment for tobacco dependence.

As I said, we had a very specific function of being able to counsel them at a moment of crisis.

Q Okay. So you didn't provide a complete treatment for tobacco dependence in this context --

A No. That's right.

Q -- of speaking to them on the telephone once?

A Right.

Q And you didn't get their names?

A Not always.

Q And you don't know if they ever called back again?

A In some cases, I mean we came to know people even without knowing their names.

Q In any case, your treatment regimen did not contemplate that you would have continuing counseling sessions with them?

A That's correct, because it was designed to be a crisis intervention service to be utilized at their initiative.

So it was quite different than the traditional treatment modality in which you would see a person repeatedly, and was not meant to be a complete substitute for it.

Q But it's still your opinion that in this context you treated people for tobacco dependence? I just want --

A I think I need a clarification of how you mean treated for tobacco dependence. I think I've characterized it in some detail.

Q Well, you understood that there's a difference between what you did with these people and what you did with the couple of people that you treated for tobacco dependence when you were working in --

A It was quite different.

Q Let me finish.

When you were working at Jeffrey Hutter's office?

A Yes.

Q There's a difference, right?

A Uh-huh.

Q What you did in Jeffrey Hutter's office would be what you would characterize as more traditional complete treatment to tobacco dependence; correct?

A It was more traditional and more intense. That's accurate.

Q It was not more complete though?

A It was more complete. I'm not sure whether it was complete since it wasn't always successful.

Q That's what I mean by tobacco -- treatment of tobacco dependence.

A Okay.

Q All right?

Prior to 1981 is there any other setting in which you provided that kind of treatment?

A Other than the ones I've already listed for you?

Q Other than Hutter's is the only one I've done.

A I've listed running smoking cessation groups in a couple of contexts, and that was meant to be treatment for tobacco dependence.

Q Okay. We're going to get to them.

But in terms of actually treating an individual person who gave you their name and who expected from you what you characterized as complete treatment for tobacco dependence --

A No. When I characterized --

Q -- you only did that in the context of your work in Hutter's office?

A No. That's not accurate.

Q Okay. Where else did you do that?

A First I want to step back.

I didn't say that it was complete treatment. I said it was more complete relative to a phone counseling context.

Q Okay.

A The two contexts that I gave you are contexts in which we ran group treatment programs for people who were trying to quit smoking.

Q Okay. Have you ever given complete treatment to anybody, or what you characterize in Hutter's office as being more complete?

A The problem of treating nicotine dependence is so difficult that I'm not sure what complete treatment is.

Q You don't know what complete treatment is?

A Let me finish, please.

MR. DARNELL: He was not finished with his answer.

A That is, our treatments even to date are -- our best efforts are not always successful, and in that sense one could say that they're incomplete.

Q Okay. Let's go to the counseling to community people which you mentioned before.

A Uh-huh.

Q Can you describe that for us?
A Yes. It would have been a group oriented treatment; that is, people would enroll and come in as a group and at that time would -- would return for a number of sessions during which we would go through a treatment program.
Q Okay. You did this under the auspices of some entity; correct?
A Correct, yeah.
Q What entity?
A I think one of them would have been done under the V.A. and one of them under UCLA.
Q Who was in charge of the one at the V.A.?
A I was.
Q Who was in charge of the one at UCLA?
A I was.
Q Was there anybody else that worked with you in the V.A. one?
A What do you mean by worked with me?
Q Is there anyone who worked with you in the UCLA one?
A What do you mean by work with me?
Q If you can't answer the question -- if you're going to ask me questions I'm just going to plow through here.

A Okay.
Q Tell me this: Who funded the one that operated in the V.A.?
A The V.A. did, I believe.
Q Who funded the one operating in UCLA?
A I think that would have been funded under the NIDA grant.
Q That's the NIDA grant that Murray Jarvik was the --
A Principal investigator of.
Q -- principal investigator?
A Uh-huh.
Q I assume that your hot line project resulted in published papers?
A It did.
Q Okay. Did this community counseling program that was funded by the NIDA grant also result in published papers?
A No, it didn't.
Q Was data collected for research purposes in connection with that work?
A I'm trying to recall. I believe that it was.
Q What was the research purpose of that program?
A We were interested in predictors of successful

outcomes. Since even with treatment many people would be unable to quit smoking or would quit and then
17 relapse, we hoped we could understand better who would succeed and who would not.

Q All right. Do you have any -- was there a report done of that work, of the results of that work?

A Do you mean by that a published report?

Q Yes.

A No, there was not.

Q Was there an unpublished report?

A I may have described for the funding agency an internal report, but I can't recall.

Q Why was it not public?

A We never really completed it, and given the funds we had, the work we did on the hot line seemed more important at the time.

Q Why was it not completed?

A That's what I mean by not -- I just told you.

Q What was it in the research protocol that was not completed?

A I believe that we did not complete the data entry and data analysis. Again, for lack of resources.

Q Were the people that came to this

community counseling program told that they were participating in a research program?

A I believe they would have been, yes.

Q What were they told?

A I better not guess.

Q You don't know what they were told or not, do you?

A I'm saying I don't recall. We're talking about something that was about --

Q You don't recall?

A All right.

Q If you don't recall, you don't recall.

A They would have certainly -- they would have been told they were participating in research along with receiving treatment.

Q By the way, were the people that called on a hot line, were they told that they were participating in a research program?

A Yes, they were.

Q Okay.

MR. DARNELL: Excuse me. Off the record.

(Discussion off the record.)

BY MR. KEARNEY:

Q Now, when these people came in for the community counseling program --

A You --

Q Withdrawn.

Could you describe what that program was?

I don't think we got to that yet.

A Okay. I can describe it broadly because I've done a lot of this sort of treatment since then.

What we did -- their views -- what we did with the next new and improved version may be a little hazy, but I will try to characterize the broad outlines.

Q Well, what I'd like you to do is try to tell me what you remember about that one and then we'll get to the new and improved version later.

A Well, we -- well, you know what, if you need for me to distinguish those then I would refer -- need to refer to documents, because frankly I've been doing this for so long that they fade together.

Q So you don't remember what you did then?

A No. I'm saying that I'm -- I don't want to mislead you and I don't want to remember as something I did then something I, in fact, did later.

I really am trying to be responsive.

Q Did you -- do you remember anything --

A Sure.

Q -- that you did in this program,

counseling to community people --

A Sure.

Q -- which you've testified is a program in which you treated tobacco --

A Sure.

Q -- dependence?

A Sure.

Q What did you do?

A We would have had a series of group meetings. It's my -- my recollection would be that it would have been about six to eight meetings of about an hour and a half.

But, again, I must tell you that that could be -- there's some guesstimating in there.

We would have analyzed -- each person would have been helped to analyze his or her own smoking patterns. We would have talked about the tobacco withdrawal syndrome. We would have talked about the possibility of relapse and the need to be alert to that. And to -- to -- we would have problems solved intensively with individuals in the group on difficulties they had had either when they were trying to quit or when they were quit and were vulnerabale to relapse.

A lot of this treatment, even though it's

done in a group is done in an individualized round-robin fashion. So a lot of it is clinically oriented. It's not that structured. It's not just follow an outline.

Q This is a discussion, free, rambling discussion?

A No. I wouldn't say that. It's a very focused, targeted discussion. Consultation.

Q How many people would be in the group?

A That would vary, but it might be ten. It would not be unusual.

Q And what would be the variance?

A Probably four to twelve, four to fifteen.

Q And how many groups of four to fifteen or four to twelve people did you have in this program at the V.A. -- I mean at UCLA?

A I'm gonna say ten, but I have to warn you that that's a ballpark figure. Again, this is --

Q Did they pay for this, the patients?

A No. I believe they did not.

Q Who was it that ran the groups?

A I ran some of them and then Laura Read, whom I've already mentioned, ran others.

Q How many did you run of the ten groups?

A I probably ran three to four.

But, again, I'm -- that's a global recollection.

Q So after these discussions what -- did you in the course of these discussions ever tell anybody to stop smoking?

A Of course we did. Not in quite that way.

Q Did any of them ever stop smoking?

A Yes.

Q What was your success rate?

A I don't know exactly.

Q How often -- let -- when were the meetings run; was it once a week, once a month?

A As I recall and, again, I don't want to mislead you, the meetings would have been on an irregular schedule. Quite intensive at first and then a bit more.

Q That they would have been planned, you don't mean irregular as catch as catch can?

A No, no. They would be planned but they wouldn't be like once a week, for example.

Q The interval would change?

A Exactly. Initially we might meet two or more.

Q What did you determine was the successful quitting --

A As I indicated, we never completed that

research project for lack of resources.

Q You mentioned prior to '81 also treating people for tobacco dependence in group treatment sessions of patients and employees at the V.A.?

A Uh-huh.

Q Who ran them?

A Again, Laura Read and I. And Joan Rauschberger may also have participated. I frankly can't recall.

Q Okay. What period of time was this?

A I'm gonna have to give you a broad ballpark.

Let's say '79 to '80. But again, I mean. I'm inferring that rather than recalling it directly.

Q Could you explain this treatment?

A It's very similar to what I've just described to you for the community people, with perhaps the exception that because some of our patients were psychiatric patients when we ran groups with psychiatric patients we were more careful.

Q How did you promote these or get people to come to them?

A As I recall, they were promoted within the Veterans Administration campus.

Q That means putting up posters on a board?

A Putting up posters or circulars to -- to all the offices at the V.A.

Letting psychologists and other treatment professionals know that this was available to their patients.

Q Did you keep records of the people that attended and make records of their -- the course of their progress?

A I believe in that instance we did not.

Q Did not?

A Did not. Because --

Q How many times did you do this from '79 to '80?

A Let me explain, that because we were treating staff people there was concern about confidentiality and embarrassment.

And, therefore, the -- what I recall is the understanding was that we would not keep records and would not create a medical record so as not to scare off, if you will, staff people who might want to seek treatment.

Q But you didn't keep records of any patients who also chose to come to these sessions; is that right?

A That's right. For the same reason.

Q Okay. What was your success rate there?

A I don't recall exactly. I do recall that it

was disappointing.

Q Do you recall anything else?

A I need more guidance than that.

Like what?

Q How do you know -- what do you recall now that makes you believe that it was disappointing?

A Well, I remember discussions that the success rate was less than in the community participants groups, and that we thought that had to do with the fact that these were psychiatric patients and the fact that even some of the V.A. staff people were -- were really very hard to quit -- very hard to treat and very dependent.

Q Unfortunately we're only up to 1981.

Where else have you treated people for tobacco dependence, in what other contexts?

A Okay.

Can I make a suggestion since we have four minutes that we break here and pick up 1981?

Q I'd like to make a suggestion we go till 12:30 so we get this out of the way.

THE WITNESS: I'd like to be able to eat.

MR. DARNELL: I think the Doctor would prefer to break now.

THE WITNESS: Or we can go to 12:15 as

agreed.

MR. KEARNEY: Let me think of a question I can ask him and he can answer in four minutes.

I guess I can't, so we'll be back here by one o'clock.

MR. DARNELL: 1:10.

MR. KEARNEY: 1:10.

(Lunch recess taken from 12:11 p.m. to 1:10 p.m.)

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A F T E R N O O N S E S S I O N

CONTINUED DIRECT EXAMINATION BY MR. KEARNEY:

Q Dr. Shiffman, have you ever consulted in any other legal cases?

A Yes.

Q Can you tell me the names of those cases and the subject matter?

A One involving Mr. Darnell as -- I believe referred to as the Haines case.

The other, I don't know if one would characterize it as a legal case. It was a legal administrative proceeding. Had nothing to do with tobacco. My role in it was as a statistical aspect.

Q What was the nature of that case?

A Let me see if I can recall it for you.

The case was in San Diego, I believe. A physician had been -- I don't know what word to use -- dismissed from the medical staff of a hospital. He was appealing the decision arguing that there weren't good grounds.

And I was engaged by the attorneys for the hospital to address the issue of whether -- whether the medical records reflected an adequate grounds for taking action against this physician.

Q When did you have your first conversation

with any lawyer concerning the Haines case?
A Would have been roughly in the middle of '87.
Q And what, if anything, did you do in that case?
A I'm not sure what you're asking.
What did I -- I met with Mr. Darnell and Mr. Edell.
Q Did you do anything else?
A I've interviewed family members.
Q When did you interview family members?
A Let me think.
I'm not really sure. It could have been late '87, early '88.
Q And who did you interview?
A The names escape me.
I think it was a Mrs. Rossi and a Mrs. Haines. I can remember the faces better than the names.
Q Pardon me?
A I can remember the faces, but I don't know the names.
Q Okay. Anybody else?
A There may have been. I believe I interviewed three people.
Q And you can't remember the third person?

A Pardon?
Q And you cannot remember the third person?
A Not right now. I've been focusing so much on this case.
Q Okay. Fine.
Why did you interview those people? What was your purpose?
A Because -- well, obviously one ground was that I had been asked to, but my purpose was to elicit information relevant to determining whether the man who died had been dependent on nicotine.
Q Were those interviews important to your development of an opinion with respect to whether or not Peter Rossi was dependent?
A They were helpful.
Q Were they necessary?
A Some sort of information certainly was necessary.
Whether it would have been necessary for me to conduct interviews myself, I don't think so.
Q All right. Did you give -- have we completed now all the cases that you have participated in?
A Yes.
Q Have you ever given any testimony in

matters other than litigation matters; administrative proceedings, legislation?

A No. Just what I told you about, that administrative --

Q Have you ever smoked?

A Yes.

Q When did you begin?

A Let me think back.

Ballpark would be maybe 1968.

Q How old were you?

A I would have been about seventeen.

Q How long did you smoke for?

A Well, I've told you when I first started smoking. I don't -- it was a period during which I wasn't a regular smoker.

But I quit, I believe it would have been 1974.

Q When did you become a regular smoker?

A Probably not till about '72 perhaps.

Q Why did you quit?

A Two reasons: One is I came to realize how unhealthy it was for me; and secondly, by that time I was already involved in smoking research, and frankly it was acutely embarrassing to be smoking.

Q In what respect was it acutely

embarrassing to be smoking?

A Well, people expected that someone studying smoking should be cognizant of the health dangers and cognizant enough of techniques for quitting to have quit.

Q How did you quit?

A I'm not sure I understand the question.

Q How did you quit?

A As I recall, part of what happened was that I was quite sick for awhile and unable to smoke without gagging and throwing up. And so I was in a sense forced to go through a difficult withdrawal.

At the end of that I decided that having made that much progress I would maintain it.

I asked help from others in my environment. I stopped cold turkey -- well, that's implicit in what I've said. I was very vigilant.

I changed other aspects of my -- my life so as to make smoking less likely, to make -- to reduce cues that might cue me to smoke.

Q Did your parents smoke?

A No.

Q Any member -- any other members of your family smoke?

A No.

Q Are you a member of any anti-smoking group?

And if I have to define that I will.

A A definition would be helpful.

Q Are you a member of GASP?

A No.

Q ASH?

A No.

Q Any group like that that has as one of its purposes to promote smoking cessation or people to stop smoking and not start, or not start and stop?

A I have been involved with The American Cancer Society, which I think has that as one of its stated goals.

But that involvement has been -- member wouldn't characterize it. I've advised them. It's not a membership sort of organization.

Q Have you contributed money to them?

A To The American Cancer Society?

I probably have, yes.

Q Have you done that regularly over the years?

A No.

Q Have you received money from them in any way?

A Yes. In -- let me be sure I give you a complete account of that.

In several ways. Again, all of them not -- in a role as a consultant to them.

I served for a time as one of the members of a committee at The American Cancer Society. This is the national office whose job it was to review research proposals and to make a scientific judgment as to their merit.

Q When did you serve on that committee?

A I need to compute it.

(Pause.)

A Does anyone have a -- I think it was roughly '83 to '86, but, again, I'm -- it's not information I keep handy.

Q Okay.

A There were other -- oh, and your question was did I receive any payment from them?

Q Right.

A And what they did was to pay us for our time when we gathered in New York to meet and discuss these proposals.

That's very standard that they would pay their experts. It was rather modest as a matter of fact.

Q What proposals did you review? Did they fall in any particular area?

A Yes.

Q What area?

A Well, the name of the committee was called Psychosocial and Behavioral Research, and it reviewed research -- really the charge of the committee was quite broad, so it reviewed any research which had to do with psychosocial or behavioral factors related to cancer.

I was essentially the expert on the committee on smoking. So within that purview I would have reviewed proposals to do with -- I'll try to characterize the range because it was quite variable -- the pharmacology of nicotine; techniques for smoking cessation; prevention programs with school children or other populations.

I've already said quitting techniques. The situations that led to smoking; the dissemination of smoking information, smoking and health information.

Now, in the course of my work on that committee I would have also reviewed proposals that had little to do with smoking; that might have had to do with, say, the reaction of children to distressing

or painful cancer treatment regimens; that would have had to do with breast cancer screening programs.

Because as I say, the purview of the committee was to review anything that had to do with human behavior as it relates to cancer.

Q Doctor, have you ever written that you are in favor of a ban on cigarette advertising?

A I don't believe I have.

Q Are you in favor of a ban on cigarette advertising?

A To be honest --

MR. DARNELL: I'm going to object to that. I don't think his personal beliefs on that, no matter what they are, are relevant.

I'll permit him to answer.

A It's not a yes or no question for me. I'm ambivalent about it.

On the one hand, knowing that smoking is very dangerous and as a citizen concerned about that I would like to see young people not take up smoking. And since I think advertising contributes to that, I see that as a social good.

On the other hand it -- I guess it's First Amendment issues concern me and I -- I don't like for us to be about the business of banning any

sort of public communication.

And so that's why I doubt that I have spoken on that on either side. I think it's a very very difficult matter and I -- I don't generally support it.

Q Have you ever spoken on the matter of forcing cigarette price increases by way of increased taxation of cigarettes?

A Again, I don't recall that I ever have.

Q Do you have an opinion on whether or not cigarette prices should be increased by way of increased taxation?

MR. DARNELL: Same objection.

THE WITNESS: You want me to answer?

MR. DARNELL: Yes, you may.

A It's a similar sort of issue.

I suppose the reason the government considers that is that A, it raises revenues, and B, if -- if something is creating a lot of morbidity and mortality and illness, then social policies that reduce that seem to me to be a good thing.

Again, I have some ambivalence about it because the -- I don't -- I don't see it and don't want it to be a moralistic issue. And so to the extent that I perceive that some people see it that

way, that makes me uncomfortable.

Q What do you mean by "a moralistic issue"?

A I mean that I sense in the statements of some people who support those policies -- I don't know how to characterize it -- a dislike or a looking down upon people who smoke. And that -- that attitude makes me uncomfortable.

Q Have you ever written about your opinion on whether or not cigarette manufacturers should be prohibited from manufacturing cigarettes?

A No, I have not.

Q Do you have an opinion on whether or not cigarette manufacturers should be prohibited from manufacturing cigarettes?

A Actually don't, because that's a huge social policy quandry so I -- I really don't have a formed opinion.

Q Have you discussed the social policy issues on that question with anybody?

A Oh, I imagine I have. I mean, it's not a new idea.

As I say, I haven't formed an opinion because I feel uncomfortable with the idea of -- the moralism that some people who hold that position seem to express about it. That makes me uncomfortable.

Q Do you feel, sir, that you are qualified to come to an opinion on whether or not cigarette manufacturers should be prohibited from selling cigarettes?

A As a matter of fact, I don't. I think that -- part of what I'm trying to say is that that is a huge, complicated social policy question and one that has to be -- is a matter of public debate and political process.

Q Have you ever participated in any forums, seminars, symposiums or meetings at which these matters were -- this matter was discussed?

MR. DARNELL: Before you answer --

When you say "participated," you mean was he physically present or did he actually speak on the issue?

Q First we'll say physically present, then we'll say participated in the sense that Mr. Darnell just referred to.

A Okay. And the question regards whether the manufacturer --

Q Whether or not you participated either by being in attendance or actually participating verbally in any meeting, seminar or forum at which the social policy issues that you testified about --

A Which social policy issues?

Q Concerning whether or not a cigarette manufacturer should be prohibited from manufacturing cigarettes was discussed.

A It's possible. I don't recall it because it's not --

Q Have you ever used any addictive drug?

A Well, I told you that I smoked, so in that sense I did.

Q When were you -- have you done any work in connection with the Haines case since your interviews with the people you said you interviewed, which was I believe Susan Haines and Martha Rossi?

MR. DARNELL: I'm not going to let you go any further on that.

I'm not counsel for Haines as you know, I've been disqualified. And I don't think it's fair to the witness or fair to counsel in Haines that you be going into that issue when they're not here.

So I'm going to direct him not to answer that.

MR. KEARNEY: His -- let me say that it is my position that his work conclusions and opinions in any situation where he has formed an opinion and made a diagnosis of tobacco dependence is fair game

for this deposition where we are taking discovery of his qualifications, ability to render an opinion in the Cipollone case, Mr. Darnell.

MR. DARNELL: You've stated your position, I've stated mine. Let's continue.

MR. BLEAKLEY: It also goes to the issue of Dr. Shiffman's bias, if any, for us to be able to explore any kind of contacts he has had with any plaintiff in any health smoking case.

BY MR. KEARNEY:

Q Did you form an opinion in your work in the Haines case?

MR. DARNELL: I'll let him answer that.

A Yes, I did.

Q You did.

And what was that opinion?

MR. DARNELL: I don't think -- I don't know that his opinion has been rendered into a form of a report.

I assume you should ask that first. And if he says it was you're certainly free to explore it. If it hasn't been done -- I don't know what's happening in Haines. I'm uncomfortable with the area because I don't know what's happening.

Q When were you first contacted by anybody

concerning the Cipollone case?

A It would not have been long after that '87 time that I at least saw materials from the Cipollone case.

Q So can you give us your best estimate as to when that was?

A Early '88. Probably later.

Again, I'm sorry, but I'm just not certain on the dates.

Q What was the first time you ever had any discussion with anybody about the Cipollone case?

A I'm not sure I can remember the very first time.

Q Can you recall who it was that you talked about the case with the first time?

A I think it was with Mr. Darnell.

Q Pardon me?

A I think it would have been Mr. Darnell.

Q Prior to that time you had no discussions about the Cipollone case with Dr. Jaffe?

A No. Dr. Jaffe and I have never had any discussions about Cipollone.

Q Have Dr. Jaffe and you had any discussions at all about the tobacco products liability cases?

A No.

Q You've never had a discussion with him about his involvement in the Cipollone case?
A I don't believe so.
Q Tell me what -- other than Mr. Darnell, whom else have you spoken to about the Cipollone case?
A Ms. Henneberry, Marc Edell, Cynthia Walters, Mr. Darnell's secretary I suppose.
And I have talked to -- I have mentioned it to people at the University of Pittsburgh just to the extent of explaining to them that I would be gone, I would be occupied with this deposition and work.
So I've not discussed the substance, but just said understand why I'm not in town.
Q And did you make any notes of your discussions with Mr. Darnell and Ms. Henneberry?
A No.
Q Mr. Edell and Ms. Walters?
A No.
Q Did they tell you not to make notes?
A No.
Q Have you come to an opinion with respect to the Cipollone matter?
A Yes.
Q When did you come to that opinion?
A The opinion would have been, you know, formed

around the time that my report was filed.

It would have been finalized, again, the date escapes me, but that was relatively recent. I think that was November.

I don't want to guess and, again, there's obviously a record on it.

Q Can you tell us what you recall of your discussions with Mr. Darnell?

MR. DARNELL: At what point in time?

Q When you recall that you had a first contact with him about the Cipollone case.

A First contact. Yes. Mr. Darnell sent me the deposition transcript of Dr. Jaffe, asked me to read it, and in part he said he wanted me to be sure I knew what I was getting into.

Q All right. Now, were you sent that before the first trial of Cipollone?

A I'm not sure what the dates of the trial were.

Q You were aware that there was a first trial in Cipollone?

A Yes.

Q And the dates were approximately the end of January till the middle of June of 1988?

A Then I'm not certain, because that falls within the time frame that I recall getting those materials

but I don't -- you know, I didn't make a record of the actual date. It would have been around that time.

Q What else was said in that conversation with Mr. Darnell when he --

A I think that was most of it. At that time I don't think he saw me nor I saw myself as being asked to provide an opinion in Cipollone.

Q Okay. Did you -- for what purpose then were you reviewing the Jaffe deposition?

A As I indicated, Mr. Darnell wanted me to be sure I understood what the deposition process was like and that -- that I knew what I was getting into.

I think he wanted me to have a sense of how good you people were.

Q What did you do after you reviewed, if anything, you reviewed the Jaffe deposition testimony?

A What do you mean by "after"? When?

Q What, if anything, did you do in connection with the Cipollone case?

A Ever since then?

Q Right. After you read the transcript of the Jaffe deposition.

MR. DARNELL: Just so we're clear, when you say in connection with the Cipollone case, for the purpose of establishing an opinion or getting ready to

give an opinion in Cipollone or because it was part of what he needed to do to get ready in Haines?

Because he may have had read something in Cipollone that had to do with Haines, but wasn't for the purpose of Cipollone, it was for the purpose of another case. So I'm not sure where you're going.

A And, indeed, that's why I'm stumbling around.

Q I get the sense then, I understand that you're reading the Jaffe deposition, in your view, in connection with your work on the Haines case?

A Initially.

Q What, if anything, did you do after you read the Jaffe deposition in connection with Cipollone or Haines?

A I have since then reviewed not only Jaffe's deposition, but also, again, I want to be sure I'm accurate and complete as far as I can be, the transcript of his testimony at trial.

Q When did you review that?

A I think that would have been after the trial was over.

Q Over?

A Yeah.

Q So sometime after June of 1988?

A Yes.

Q All right. What else did you do?
A I reviewed the depositions of family members, both -- well, actually firstly Mrs. Cipollone's deposition.
Q When did you do that, Doctor?
A That would have been later. In 1990. I'd say the second half of '90, in the fall.
Q Did somebody ask you to do that?
A Yes.
Q Who did?
A I believe that would have been Mr. Edell or Ms. Walters.
Q All right. And you understood that was in connection with the Cipollone case?
A Yes, I believe that by that time they had asked me whether I would be prepared to render an opinion on Mrs. Cipollone, and I said that I would.
Q Can you tell us when you had -- when was your first conversation with Mr. Edell or Ms. Walters respecting Cipollone?
A You know, I'm not really sure.
Q All right. Can you give me the substance of the conversation?
A The substance would have been that the matter had been returned on appeal for retrial and that they

asked me, you know, whether I would be willing and available to review materials and render an opinion.

Q Is that over the telephone or was it in person?

A Over the telephone.

Q Did you ever meet with them after that?

A I've never met Ms. Walters. I've met -- I met Marc Edell.

Q When did you meet Marc Edell?

A Now that hadn't to do entirely to do with Haines, so I don't know.

Q All right. When was that?

MR. DARNELL: You can answer it.

THE WITNESS: Okay.

A Oh, no, no. I can be more exact. August 1990.

Q And where was that meeting?

A Seattle, Washington.

Q Did you make any notes of that meeting?

A No, sir.

Q Have you ever had any correspondence with Ms. Walters or Mr. Edell?

A Written correspondence?

Q Yes.

A Our correspondence has consisted pretty much of cover letters, letters of transmittal.

I've not -- I have not sent -- they've sent me a lot of documents, but not correspondence.

Q Was there any discussion in this August 1990 meeting in Seattle with Mr. Edell about the Cipollone case?

A No.

Q What was discussed about the Haines case?

MR. DARNELL: I'm going to object to that. He can answer it.

A In fact, it was less about the details of the Haines case than Mr. Edell had read some of my published writings and wanted to ask -- was kind of checking out his understanding of what I meant in various writings.

Q Okay.

A So we didn't -- we didn't much talk about Haines per se, although it was very clear in the context that -- in fact, at that time I had no idea that -- I don't even even think I knew Cipollone had been returned for trial.

Q What did -- what have Mr. Edell or Ms. Walters, or Mr. Darnell for that matter, told you about the outcome of the addiction issue in the first trial of Cipollone?

A What they said was that the jury had -- I'm

trying to remember. That the jury had assigned a substantial amount of -- there's a legal term here.

Q Responsibility?

A I can't remember. Yeah, responsibility to Mrs. Cipollone.

And I saw that as -- and I think they saw that as reflecting some, I don't know, reflecting their response to the addiction issue I guess.

Q So that what you're saying is that you discussed the fact that the jury found that Mrs. Cipollone's smoking was knowing and voluntary?

A I don't think that's how they characterized it and it's not how I would characterize it.

I don't know that the jury -- I honestly just don't know legally whether that's what the jury said.

Q And I'm not -- I'm just asking you if there was a discussion about that.

A No.

Q But you understood that when the jury found that Mrs. Cipollone was 80 percent responsible, that that had something to do with the addiction issue?

A Yeah.

Q And you understood that that meant that

the jury did not buy the addiction business. Is that basically it?

A No. That's not how I would characterize it.

Q Tell me what it is. Tell me what you understood the connection was between the 80 percent -- finding of 80 percent responsibility and this -- the addicition issue in the Cipollone case.

A That they felt she was partly at fault.

Q Have you had any discussion with any of those lawyers concerning the testimony or opinions offered in the first case by Dr. Jaffe?

A Uh-huh.

Q Tell me about those discussions.

A Let me try to recall them.

(Pause.)

A What's the question again?

I'm sorry. I'm just fading out.

Q I asked you to tell me the substance of the discussions that you had with any of those lawyers that we've mentioned concerning the testimony and opinions offered by Dr. Jaffe at the first trial or at his deposition.

A Right. I think we -- we talked about how difficult a deposition was.

We talked about Jerry's background and

expertise. We talked about his style of presenting evidence. We talked about his -- his conduct of the interview of Mrs. Cipollone.

Q Anything else?

A Not that I can recall right now.

Q Did you discuss the nature of his opinions in the case?

A Uh-huh.

Q What discussions did you have with the lawyers about the conduct by Dr. Jaffe of his interview with Mrs. Cipollone?

A We talked about basically that he had -- there were some things that he later was embarrassed by and wished he had asked, I wish he had asked, that it was in retrospect imperfect. That was most of it.

Q And in what respect imperfect?

A Well, he was, as you know, at the time unaware that she had consulted a psychiatrist and so hadn't apparently asked about that. Didn't have an opportunity to pursue that with her.

He -- you know, there were times when the time frame of his questions were not clear.

Q Meaning what?

A Well, there were times when he asked her about some response to something and it wasn't clear when he

was asking about.

Q Whether he was asking about 1983 when the interview was conducted or whether he was asking about 1981 when she stopped smoking?

A No. That was usually clear.

Q Tell me then what you mean.

A When he -- when she described routing in the garbage can for cigarettes he didn't ask when that was. That was an example. So --

Q What was discussed about the content and nature of his -- of his opinion?

A I'm not sure what you're asking different from what I've just answered.

Q All right. In your discussions with the lawyers -- and you understand by that I mean to include Ms. Walters, Mr. Edell and Mr. Darnell.

A All right.

Q What was discussed about the nature and content of Dr. Jaffe's opinion in this case?

A They asked me whether I agreed with the basic substance of it, and I said that I did.

Q And what was the basic substance of it that you understood you agreed with at the time?

A That nicotine -- well, let me -- let me be sure to answer this accurately.

That nicotine is a -- an active, psychoactive drug. That Mrs. Cipollone was dependent on nicotine and smoking. That was the basic substance.

Q Now, you've -- have you read the Jaffe trial testimony or deposition since you read them back in 1988 and '87?

A Yes, I have.

Q And you read them in preparation for this deposition?

A Yes, I did.

Q Is there -- and you made notes about them?

A Correct.

Q And you studied those notes in preparation for the deposition?

A Correct.

Q Is there anything that you disagree with that Dr. Jaffe said in his opinions in this case, in giving his opinions in this case?

MR. DARNELL: Don't answer that question. That's entirely too broad.

If you want to confront him with a statement that Dr. Jaffe made or confront him with a part of his notes and ask whether this indicates some

disapproval or disagreement, we provided them to you. Go ahead.

But I think it's unfair to ask a witness to characterize several, almost a thousand pages of testimony between the deposition and the trial testimony, and ask him whether he agrees with it. So I'm going to have to direct him not to answer.

Q Is there anything that you can think of right now in those -- in that testimony that you've read and reviewed that you disagree with?

A I really would prefer to have the notes in front of me if you'd like to --

Q Is it a fact that you can't answer that question?

A Well, I want to be as factual and accurate as possible.

Q I'm just going to continue. I'll get back to that later.

What else did you do in connection with developing your opinions -- your opinion in this case which you said was formed in and about the time of your report, which I represent to you is dated November 30, 1990?

A That sounds right. I read it.

Q Excuse me just a minute, Doctor. You're

going to have to I think speak up --

A Sorry.

Q -- so that she can pick up everything.

A Okay. I read the deposition testimony of other family members. That included Anthony Cipollone. It included Rosalie Langshultz.

I have to remember all the names here. Thomas Cipollone. Maria Jordan. There was someone named Deglio, I believe. I don't remember the first name.

Q Tomasina?

A That sounds right.

There was -- there were others. Let me just think.

(Pause.)

A I'm blocking on the names, but there were others. I guess you know I made notes on most of them.

Q Rosalie Langshultz?

A Rosalie Langshultz. I thought I had mentioned her.

Q You may have.

And the son-in-law, Rosalie Lanshultz's husband's deposition, did you read that one?

A What was the name?

Q Ken I think. Ken Langshultz.
A I don't believe I did that.
Q William Jordan?
A Oh, I think I did read that one. Yes.
Q Thomas DeFrancesco you read?
A I did read that.
Q Did you have occasion to meet with Mr. Antonio Cipollone before he passed away --
A No.
Q -- in the winter of '90?
A No.
Q Would that have been useful to your ability to get all the facts in order to give an opinion here?

MR. DARNELL: I think he passed away in the winter of early 1990.

Q I'm sorry. If I didn't say that I misspoke.

MR. DARNELL: Winter could be December of 1989 or it could be January 1990.

I think he passed away in the beginning, right after, within days of the third circuit's opinion. A day or two before, a day or two after.

Q Can you answer my question?
A Did I have an occasion to meet with him, no.

Q Would that have been useful for your opinions?

A I don't think it would have been very useful because as you know, he was very thoroughly deposed. So I felt I had most of his information available to me.

Q You would prefer to read a deposition than to interview --

A No.

Q -- a family member?

A No.

Q It would be more useful to read a deposition than to interview a family member?

A No. It would be slightly more useful to interview a family member.

But most of the information that was relevant was asked repeatedly, so I felt I had adequate -- an adequate sense of his reports.

Q Did you interview Thomas Cipollone before you formulated your opinions in this case?

A No.

Q Did you ask to?

A No.

Q Did you interview Rosalie Langshultz before you formulated your opinions in this case?

A No.

Q Did you ask to?

A No.

Q Did you interview Maria Jordan?

A No, I did not.

Q Did you interview Mrs. Cipollone's brother and sister?

A No.

Q Did you ask to conduct any of those interviews?

A No.

Q Why not, if the interviews would be more useful than reading their deposition?

A There -- that's -- you asked me two different questions. One is was it more useful and one was what I prefer to do.

Being a clinical psychologist I'm more accustomed to interviewing people than to reading depositions.

However, I didn't ask to because it seemed to me that they had been asked, exhausted ad infinitum and, if anything, some of the people who were interviewed essentially made it clear that they had little relevant information. So it didn't seem to me to add much to what I already --

Q They had little relevant information given in the course of their deposition?

A Relevant to assessment of dependence in that some of them had little recall of details of her smoking behavior.

Obviously they have given information relevant to other matters, but it didn't seem -- didn't seem to add much; that is, that the depositions were rather thorough.

Q Well, that's two different things; deposition is thorough and not adding much to your opinion. Which was it?

MR. DARNELL: Or both.

A Both.

Q Pardon me?

A Both. It wouldn't have added much because the depositions were rather thorough.

Q In your work in the Haines case you opted to interview Susan Haines and Mrs. Rossi instead of reading their depositions; correct?

A Right.

Q Why did you do that if the depositions are generally better than the personal interviews?

A Actually, I don't even know that they have been deposed. At this -- to this point I've not seen

depositions.

Q But did you ask the lawyers to interview those people, for permission to interview them?

A Yes. And the context was different. We were just starting.

Here I had before me the depositions and they seemed to me to be adequate to form an opinion. In that case I had no depositions and I opted to interview them as a way to gather information.

Q The lawyers didn't tell you that at that time, that these people had already been deposed?

A I don't recall that they have. As I say, to this point I couldn't tell you whether they have or not.

Q Has anybody told you that you can't interview Thomas Cipollone --

A No.

Q -- for the purposes of your opinion in this case?

A No, they have not.

Q What else have you done in connection with -- let me -- did you read all these depositions before November 30, 1990?

A I at least browsed through them looking for relevant information.

I have since read them more thoroughly and made more thorough notes. Looked to see if there were relevant elements in the depositions at that time.

Q What else have you done in connection with formulating your opinion?

A Well, I have read Dr. Jaffe's report in Cipollone.

I've examined his -- or copies, I should say, of his notes and materials related to that interview.

I have looked at the Surgeon General's report, but that's something I do anyway.

Q Did you do that prior to formulating your opinion in November of 1990?

A Did I read the Surgeon General's report?

Q Right.

A Yes.

MR. DARNELL: Just for clarity, are we talking about the nicotine addiction report?

THE WITNESS: Oh, sorry.

A Yes.

Q Okay. What else did you do?

A I sat and thought a lot.

I made notes that I believe you have

seen. I made outlines, tried to cross-reference different sources of information.

I think that adequately describes it. I can't -- it's been a substantial period of time and a rather busy one, so I think -- I think that captures it all.

Q Why did you read Jaffe's report and the notes that he took at his interview with Rose Cipollone and the other materials that he said he used at his interview with Rose Cipollone?

A They seem to me to be relevant to making an assessment of Mrs. Cipollone's dependence on nicotine.

Q Okay. You mentioned in one of your prior answers that you had --

MR. KEARNEY: Well, let me have this document marked as the next document. Let's start with that.

(Letter dated 11/30/90, Walters to counsel for defendants with attachments, received and marked as Defendant's Exhibit Shiffman-10 for Identification.)

Q Doctor, I'm going to show you a letter from Cynthia Walters to counsel for defendants marked as Shiffman-10, dated November 30, 1990.

Other than my marks on the top, "File

Shiffman" and some underlining I've got on the second page, I'm going to ask you if you have seen this document prior to November 30, 1990.

(Witness reviews.)

A Yes, I believe I did see this document.

Q Tell us how it was prepared.

A There were discussions I think initially with Mr. Darnell. That was at about the time that he got -- he had to excuse himself for another case. I forget the exact time line.

So we discussed -- we -- most of the discussion took place with Marc Edell and Cynthia Walters.

They asked me about my opinions. They drafted the letter and asked me to review it to make sure that it was an adequate -- you know, that it was a reasonable representation of my views.

And I -- I believe that this is the -- the version that I approved.

Q All right. Can I have it?

A Sure. Let me just --

Q Take your time with it.

(Witness reviews.)

Q Okay. Can you tell me what your opinions are in this case?

A As stated in the document, I believe that Mrs. Cipollone was dependent on smoking and nicotine.

Q Do you have any other opinions?

A Yes. It goes with the concept of dependence as I mean it. That that made it very difficult for her to quit smoking and impaired her ability to -- to act flexibly with regard to smoking and to, you might say, dispassionately evaluate or process information about the hazards of smoking.

Q Anything else? Do you have any other opinions?

A Well, maybe if you could give me some more guidance I'd have an answer.

Q I'm not your lawyer.

A Right.

Q Have you come to any other --

MR. DARNELL: I should say, Doctor, if you have to review any notes or look at any documents in order to help you with that, go ahead and do so if you think it's necessary.

This is not a closed book test.

A Okay. Well, I can look at the report again perhaps.

Q Fine.

(Witness reviews.)

A Well, maybe I can expand on that.

I have said specifically that Rose Cipollone was dependent on smoking and nicotine. I would further state that nicotine is a dependence producing drug, and so that she was typical in that respect.

As I've said, I think that made it -- made her smoking behavior very compulsive and difficult to change, and she was aware of that difficulty.

(Alan Naar, Esq. arrives.)

THE WITNESS: May I be introduced?

MR. DARNELL: Alan Naar from Greenbaum's office.

THE WITNESS: All right.

MR. DARNELL: New Jersey counsel for Liggett.

BY MR. KEARNEY:

Q Have you completed your answer?

A That -- that gives the broad outlines of my opinions.

Q All right. Tell me, when did Mrs. Cipollone become aware of her difficulty in changing her smoking behavior?

A I would say that at the very latest it would

have been in 1947 when she was pregnant and trying to quit smoking during that time.

Q So it could be that before that she was aware that she had difficulty or would have difficulty in changing her smoking behavior?

A It's possible, although it seems as though from the way she talked about it that it was in '47 that that was brought --

Q So she understood that then?

A I believe so. I'm not -- to be clear, I'm not saying she would have been able to verbalize it. But see, her experience would have been compelling.

Q When was she first able to verbalize it?

A May I look at my notes? Because I believe she made statements to that effect because I don't know what the time frame is.

Q When did she make statements to that effect?

MR. DARNELL: He just said he didn't know.

A At her deposition.

Q At her deposition?

A She spoke about things she had said in the past.

Q So was there any time before her

deposition that she was able to verbalize the fact that she was aware of difficulty in changing her smoking behavior?

A Let me try to be clear.

What she reported at her deposition was partly statements she said earlier. So what I'm not -- I'm saying that her deposition contained reports of earlier statements.

Q What would you need to look at, sir, to answer my question?

A It would be helpful if I could look at her deposition and my notes of her deposition if you want an exact time frame. She may well have verbalized it with regard to '47.

Q Okay. You said that Rose Cipollone was dependent.

Could you define for us your definition of dependent?

A Dependence is a condition growing out of chronic use of a psychoactive drug. I should say that the condition has the characteristics of a syndrome; that is, it has many facets, not all of which need to be present in the same degree.

And among them are the development of tolerance to the drug; the emergence of a withdrawal

syndrome on cessation of the drug. Compulse -- the person's use of the drug becomes compulsive. It becomes less flexible than other behaviors. It's characterized by being less responsive to situational conditions, by being less responsive to other -- being weighed with other values or organic needs.

It becomes, therefore, less completely voluntary. It's marked by difficulty changing and especially stopping the drug use, and by a tendancy to resume drug use if the person is able to stop it.

And it often produces strong urges or cravings for drug use.

Q Anything else?

A That's all for now.

Q Now, I'd like you to tell me whatever else there is that you can recall right now.

You're not holding back anything that you can recall --

A No.

Q -- are you?

A No.

Q When did Rose Cipollone become dependent on smoking nicotine?

A I believe that at least by 1947 she was dependent.

Q She was dependent in 1947?
A Correct.
Q Pardon me?
A Correct.
Q And that was during the time period when she was not -- when she quit or cut down during her pregnancy, during that time period she was dependent?
A She did not quit, in my opinion, from the way I read the facts. During that time I believe she was dependent.
Q And you're an expert reader of depositions?
MR. DARNELL: That was a snippy question. You need not answer it.
Q What do you base your conclusion on that she -- did you read the deposition of Tony Cipollone?
A Yes, I did.
Q What did Tony Cipollone say about her smoking in 1947?
A May I look at my notes to refresh my memory?
Q Sure.
MR. DARNELL: Just so we're clear, have you marked all the notes that we've produced as exhibits?
MR. KEARNEY: Well, in the course, Alan,

we will put them on the record.

MR. DARNELL: It seems easy for him to look at what's on the table instead of -- and start digging.

MR. KEARNEY: Absolutely.

MR. DARNELL: May I have a representation from you that each of the various sets that I delineated in my cover letter of -- was marked?

THE WITNESS: I can go get the --

MR. DARNELL: Look here. Let's take a five-minute break so we can all stretch.

THE WITNESS: In fact, I don't see here the deposition, my notes on the deposition of Tony Cipollone.

Sorry. Sorry. It's just stapled.

(Recess.)

BY MR. KEARNEY:

Q Dr. Shiffman, did Mrs. Cipollone exhibit a tolerance to cigarette smoking?

A Are we switching from the question I was addressing in -- I thought I went out to look at this to address a question?

Q I did not put this question to you before. It's a different question.

MR. DARNELL: If he doesn't want his

question answered, that's fine.

A That's okay. I'm just not used to it.

Yes, she did.

Q Can you describe how she exhibited tolerance to smoking?

A I can give you a couple of examples.

She started out, she stated, by smoking two to three cigarettes a day. Within a period of a year she was smoking 20. As she described it, that would indicate tolerance.

The other example is appropos of what we were just discussing. During her pregnancy she described smoking a few a day, but when she described the -- the experience of her smoking at the time of delivery, I guess this would have been Maria Jordan's delivery, she said she then had a pack within 24 hours.

That would indicate tolerance in that if you took a naive person, by which I mean not a room but someone who hasn't smoked, and they smoke a pack, they basically physically couldn't. They would experience toxicity.

So that goes to show that her body had learned to tolerate nicotine, and indeed it goes to show that that tolerance persisted over the course of

her pregnancy.

Q Any other examples of tolerance?

A I think she also -- there was some escalation in her smoking over the course of time to something over a pack a day, but I think those are the main indicators of tolerance here.

Q None others?

A Pardon?

Q I want you to tell me not the main ones, I want you to tell me all the instances where you believe her behavior exhibited tolerance to cigarette smoking.

A Okay. I will try to enumerate all of them.

Again --

Q Not the ones you just gave us, if there are any others.

MR. DARNELL: Additional ones, if you have any.

A Right. I just -- without going through every line of the deposition I will try my best from the notes that I have.

Q Let me -- did she smoke more when she switched to lower yielding filter cigarettes in the late '60s and early '70s?

A That is unclear. So I'm not basing my opinion

of tolerance on that.

Q So you don't know whether or not she compensated?

A No, I didn't say that. I say it's not clear that she smoked -- there are other ways to compensate.

With regard to indicators of tolerance, she reported that sometimes she smoked up to 40 a day and she -- and others reported that she sometimes lit one from another.

Again, such behavior in an intolerant person would produce severe toxicity. So her ability not only to tolerate it but to not show adverse, immediate toxic effects goes to speak to her tolerance to nicotine.

Q Okay. Did she exhibit withdrawal?

A She did exhibit withdrawal to some extent in 1947 and again --

Q Could you explain what withdrawal she exhibited in '47?

A First let me say again, that as I understand her testimony at deposition she reported not quitting, but cutting down.

Q To what?

A Pardon?

Q To what?

A Let me look that up so I can answer that correctly.

(Witness reviews.)

A She implies that to just a few a day.

And she states the relevance of that is that she gives some evidence of having essentially tried to minimize withdrawal with that smoking.

So I don't think her withdrawal was severe because she didn't let it get to that point, but she exhibited withdrawal and she exhibited --

Q She exhibited withdrawal but not severe withdrawal in 1947 when she cut down; correct? Is that what you're saying?

A I'm saying because she essentially didn't act to keep it from getting more severe.

Q Well, didn't -- haven't you done studies, Doctor, that say that people who cut down actually -- rather than quitting cold turkey, actually show higher and more severe withdrawal symptoms than the people who just stop completely?

A What that research actually shows is that cutting down prolongs withdrawal. It doesn't make it more severe, it prolongs it, and indeed I think that she did that.

Q I agree. I agree with what your

statement is about that, what your results were in the study.

MR. DARNELL: And you further agree that you mischaracterized those results in your previous question?

MR. KEARNEY: I absolutely do, and I stand corrected. But my point is still made.

BY MR. KEARNEY:

Q Does that demonstrate to you that her smoking during that period of time was compulsive?

MR. DARNELL: Excuse me. During that period of time is this?

Q During 1947 when she was pregnant and she was smoking a few a day, does that demonstrate to you that during that period of time her smoking was compulsive?

A The fact that she continued to smoke when she stated she wanted to quit, had been urged to quit and that she was unable to stop smoking, does -- is one of the pieces of evidence supporting a compulsiveness of her smoking.

Q It's your conclusion that at that period of time she wanted to quit entirely, and that's your conclusion?

A That's my understanding of her deposition.

Q Is it possible --

MR. DARNELL: Excuse me. He wasn't finished and you started talking. That's not polite.

Would you like to finish your answer, Doctor?

THE WITNESS: Sure.

A That is what I understand her to have testified.

MR. KEARNEY: Could I have the question and answer read back, please?

(Testimony read back as follows:

"Question: It's your conclusion that at that period of time she wanted to quit entirely, and that's your conclusion?

"Answer: That's my understanding of her deposition.")

BY MR. KEARNEY:

Q And you rely on her statement in her deposition about her motivation in 1947?

A In part and on the context.

Q Pardon?

A On her testimony and on the context, that includes Tony's testimony about that context.

Q You discount the possibility that in 1947 she simply wanted to cut down to a few cigarettes a

day?

A She -- if -- the fact, for example, that she hid her smoking from her husband, that she acted furtively and guiltily, says to me that she was essentially experiencing a sense of failure, difficulty and inability to quit.

And indeed I believe in her deposition she testified to how difficult it was, so I think that she was trying to quit.

Q Do you disagree with Dr. Jaffe in his opinion that in 1947 she was not dependent on cigarettes?

A Yes, I do disagree with that.

Q And what's your basis for that disagreement?

A Let me see if I can explain it.

I believe that her continuing smoking, the furtiveness, her description which seems to imply smoking for the purpose of relieving withdrawal symptoms, is consistent with continued dependence.

Further, her -- her rapid relapse and quick rise to 20 cigarettes in the first 24 hours speaks to continued dependence.

So I disagree with Dr. Jaffe's opinion that she was not dependent during that time.

Q Do you -- is it your belief that she continued to smoke 20 cigarettes a day or a pack a day persistently after the delivery?

A What do you mean by persistently?

Q Every day.

A I couldn't guarantee every day, but most of the evidence that I have suggests that she did.

Q So you don't know, though, that this quick rise that you just referred to in your last answer continued after the actual 24 hours of labor, do you?

A Well, that is -- that's very different than saying every day.

So she -- in fact, I believe this -- I don't remember who was deposing her. I believe if it was you, that you asked her and she indicated that she did then go back to smoking 20 a day.

I'm also stating that even the ability and actual behavior of smoking 20 that first day would itself be an indication of continued dependence even if she had known the next day.

Q If she was told that cigarette smoking was dangerous to her health in the late 1940s would she have been motivated to stop smoking?

MR. DARNELL: Told by whom?

MR. KEARNEY: Told by anybody.

A That may have motivated her to quit smoking, particularly if she had been able to accept it.

Q Would she have been able to accept it?

A In '47? I think she -- she would have had some difficulty accepting it as a result of her realization of her difficulty or inability to quit.

Q Would she have been able to have made a decision to stop smoking?

A What do you mean by make a decision?

Q Decide I want to stop smoking.

A As simply as that though?

Q Pardon?

A As simply as that?

Q Yes.

A Been able to state I want to smoking?

Q Would she have been able to do that?

A Yes, I believe she could.

Q Would she have been able to quit if she wanted to?

MR. DARNELL: I object.

You haven't defined the term "want."

THE WITNESS: Right.

A I think --

Q Would she have been able to quit? I'll

drop out if she wanted to.

A If her -- if she had been able to grasp fully, completely in this personalized direct way how it was harming her health I think she may well have been able to quit.

Q What do you mean by personalize in a direct way how it would have harmed her health?

A I mean that there is a difference, just as there is a difference in degrees of wanting to quit, there is a difference in degrees of grasping the health impact.

So that one can -- the degree to which -- there are -- there's variability in the degree to which a person sees themselves at personal risk and, therefore, personalizes the information in terms of applying a statistical risk construct to themselves.

Am I making that clear?

Q So if Rose Cipollone's doctor told her in 1947 that cigarette smoking could endanger her, all right, you're telling me that that would --

No. Withdraw that.

If Rose Cipollone's doctor told her in 1947 that cigarette smoking could endanger her health, would she be motivated to stop smoking?

A Again, I have to answer the question in terms

of degrees; both degrees of motivation, particularly because I believe in 1947 she was motivated to stop smoking, and also in terms of degrees because it would matter how her doctor told her and how she processed and received the information.

Q Well, you studied her. You know, I'm asking you. Don't tell me what matters, just tell me what your opinion is.

Would she have been motivated to quit smoking if her doctor told her in 1947 that cigarette smoking could endanger her health?

A Would she be motivated, yes, I believe she would.

Q Would she try to stop?

A I believe she did try to stop.

Q And would she be able to stop?

A I think if she had more fully than she did grasped the health information and personalized it that she might well have been able to stop at that time.

Q How did she -- how much did she fully grasp and personalize that information at that time in 1947?

A Not very much.

Q Pardon me?

A Not very much.

Q What's your basis for saying that?

A Well, she reports, for example, that firstly the health information that was provided her at that time she saw as being focused on the baby rather than on her.

And she stated that it didn't produce -- she reports sensing that Tony was concerned, but not personalizing it enough to become more concerned herself.

She was somewhat concerned, she did seem to hear -- she could report that she was told it, but I don't believe that she was able to grasp it.

Q In the early '60s, all right, if she believed --

MR. DARNELL: Now we're jumping ahead many years.

Q If she believed that she could get lung cancer from cigarette smoking would she have been motivated to try to quit?

A Again, I need to qualify degrees and kinds of belief.

I think that at that point she had trouble believing it in part for two reasons.

In part because -- in large part because

being aware of her own dependence and difficulty quitting made it hard for her to grasp and absorb that information, and because she also was relying on other information that minimized the risk in her eyes.

Q I'm asking you to assume that she did believe that she could get lung cancer from cigarette smoking.

Would that, Doctor, in your professional opinion have motivated her to try to stop smoking?

MR. DARNELL: Before you answer that --

Is this an assumption that you believe is based on fact or an assumption that you are asking him as a hypothetical?

MR. KEARNEY: What difference does it make?

MR. DARNELL: Because I think you have to have a good faith bases for your question.

And if there were no facts to suggest that she actually believed that, then I suggest that that question is irrelevant and not appropriate to be answered.

MR. KEARNEY: Are you going to direct him not to answer?

MR. DARNELL: I didn't say that.

I'd like to know if you're representing

that your good faith bases are grounded in fact rather than some conjecture on your part.

BY MR. KEARNEY:

Q Proceed with your answer.

MR. DARNELL: You haven't answered my question, Mr. Kearney.

Are you representing that you have a good faith bases for that based on the facts in this case?

MR. SIRRIDGE: If that's an objection to form, Al, why don't you make it?

MR. DARNELL: I did.

MR. KEARNEY: Let's proceed.

MR. SIRRIDGE: Thank you.

MR. DARNELL: You can answer.

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A If she had been able to fully weigh and personalize the risk, I think she would have been motivated to quit smoking.

Q Do you think that Mrs. Cipollone, or rather let me put it another way.

Had she believed that she could get lung cancer from cigarette smoking, could she have stopped smoking? Was she capable of stopping smoking?

MR. DARNELL: Time frame?

Q Is a time frame important to that question?

A Of course, yes.
Q Why is that?
A Because addiction often has a progressive character and, therefore, it makes a difference when it was based on what her experience had been with smoking, and also on her experience with quitting.
Q Let's take the early to mid '60s. That's the time frame for that question.
A Okay. And what's the --
Q The question is if she believed she could get lung cancer from cigarette smoking, was she capable of stopping, Doctor?
A I think by the late '60s it would have been extraordinarily difficult for her to stop.
More likely than not she would have failed.
Q Would it have been impossible for her to stop?
A Psychologists rarely deal in impossibilities.
Q What about 1963, Doctor? Not the late '60s. Same question, 1963.
A '63.
Q Would it have been impossible for her to stop smoking?
A I --

MR. DARNELL: Just so we understand, the question is would it have been impossible for Rose Cipollone to stop smoking in 1963? Is that the question?

MR. KEARNEY: That's not the question.

MR. DARNELL: Well, then I'm confused.

BY MR. KEARNEY:

Q The question is: Had she believed that she could get lung cancer from cigarette smoking, from her cigarette smoking, right, could she have quit smoking in 1963?

A Again, I want to qualify that there are degrees of belief, and so I'm a little uncomfortable using that as though it were simple. If -- in '63 if she had believed it, personalized it, would she have been capable of quitting.

And you're positing that as a contra-factual because I don't believe that she did really grasp it. You want her -- you want me to assume that whether I think it's true or not?

Q Does your answer change, Doctor, whether it's a contra-factual hypothetical or actual hypothetical, does your answer change?

A No. I just want to be sure that you're clear about the assumptions on which I'm answering so that

our assumptions don't differ and you don't misunderstand my answer.

I think it would have been extraordinarily difficult for her, but possible.

Again, you're asking me to characterize things as possible or impossible and that's not -- not how we tend to operate.

Q Was it extraordinarily difficult for her to quit in 1981?

A Apparently yes.

Q Was it extraordinarily difficult for her to quit in 1947?

MR. DARNELL: You're assuming she did quit. And the Doctor's testified she didn't quit based on his understanding of the facts, so I think that your question is not proper.

Q Was it extraordinarily difficult for her to cut down to a few cigarettes a day in 1947?

A She indicates that it was very difficult in 1947.

Q So even though it was extraordinarily difficult for Rose Cipollone, she could, in fact, stop smoking cigarettes. You agree with that?

A She didn't stop.

Q Pardon me?

A She didn't stop in '47.

Q She stopped in '82, didn't she?

A Part of what goes into the motivational equation is not only how difficult it is and how you -- but also what -- what kind of gun is being held to your head.

The fact that at that time she had had parts and then a whole of the lung removed essentially overcame that difficulty.

Q So she did not have extraordinary difficulty in quitting smoking?

A No, I didn't say that.

I said it was difficult but she was able to do it at that time.

Q All right.

A In fact --

Q Now, when you say it would be extraordinarily difficult for her to have stopped in '63 under the hypothetical -- withdrawn.

Can you describe just how difficult it would have been for Rose Cipollone to stop smoking in 1963 had she been aware, had she believed that she could get lung cancer from cigarette smoking?

A If I may, perhaps I can use her own words because I think she talked about that.

MR. DARNELL: Go ahead.

Q Let me ask you this question before --

MR. DARNELL: You've asked your question. Are you now abandoning the question or do you want him to answer it before he starts checking what he thinks he has to check to answer it?

Are you abandoning the question? And if so, you can put that down. If you're not abandoning the question I think he's entitled to know.

MR. KEARNEY: I'm abandoning the question

Q As an expert in this field, Doctor, am I correct that you cannot answer my last question without looking to see what she said in her deposition?

A I think it's relevant to --

Q The only way you can articulate --

A Let me finish.

Q -- the degree of difficulty in --

MR. DARNELL: Now wait a minute. Excuse me.

Q -- her stopping smoking in the early '60s is by looking at what she said in the deposition after this case began; is that correct?

MR. DARNELL: You know, we're now getting to the point where you're -- he started to answer it

and you started -- you cut in on his answer with a third question and that's not fair.

Now, he's not going to say anything until you -- you're not going to say anything until he answers your second question unless you've abandoned that, too.

I think it's unfair for you to keep asking questions, he starts to answer it, you think better of it and you ask a third question in the middle of his answer.

And I think -- so we'll allow the Doctor to collect his thoughts. Given what I foresee as a harassment process at this point, we're taking five minutes and then we'll start again because I don't think this is fair. We're taking a five-minute break.

If you want to ask him -- if you want him to answer questions, let him answer it before you start asking your next one. We're taking five.

MR. KEARNEY: Mark the time at 3:10.

(Recess from 3:10 to 3:15 p.m.)

MR. KEARNEY: Can we go ahead?

MR. DARNELL: Yes.

BY MR. KEARNEY:

Q Dr. Shiffman, did you just have any discussion with Mr. Darnell during the course of this

last break?
A Yes.
Q Tell us what was said by him and what was said by you.
A He said that I ought to just answer the questions, not be intimidated. That -- not allow myself to have my statements kind of turned around. To try to be clear about what I was saying.
Q What else did he say?
A That was about it.
Q Did you talk at all about the subject matter of testimony that you were just covering?
A No.
Q Let's go back now.
In 1963, 1964 had she believed that cigarette smoking could cause her lung cancer --
A Uh-huh.
Q -- would she have been motivated to try to stop?
A Again, let me say that it depends in part on the degree of personalization of the belief.
But had she believed it completely, yes, I think she would have been motivated to stop.
Q Having been so motivated would she have been able to stop?

A I think it's likely. Again, it would have been extraordinarily difficult, but I think she probably would have been able to.

Again, I want to make it clear that I'm uncomfortable dealing in absolutes.

Q Describe, Doctor, what you mean by "extraordinarily difficult" in that last answer.

A I mean that it would have caused her substantial distress and that the probability of success would have been low.

Q Tell me what the probability of success would have been.

A I can't put a number on that.

Q Would it have been -- can you give me a range, Doctor?

A It would have been low. That is the range.

Q Now, I'm really -- frankly, I don't understand what you're doing.

I thought you just told me she would have been able to stop but it would have caused her great difficulty.

A Right.

Q Now you told me she had a low probability of stopping.

Would she have been able to stop with

that belief in the early '63, '64 period, yes or no?
A It's not a yes or no answer.
MR. DARNELL: Doctor, if you can't answer it yes or no, don't answer it yes or no.
A That's what I was going to say. It's not a yes or no question.
I think -- I want to acknowledge that there was a -- some chance she would have succeeded. It would have been difficult. It would not have been easy. And I mean by that, both that it would have been experienced as very difficult and that the probability of success would have been low.
Q So you're saying more probably than not she would not have stopped in 1963 had she believed that cigarette smoking could cause her lung cancer, she would not have been able to stop smoking?
A Again, I think she might have been able to. I think it would have been difficult.
I think it would -- it would not have -- it wouldn't have been a high probability of success.
Perhaps 50 percent is a reasonable one but, again, you're asking me to cast things in a term -- in terms of specific numbers that are just not reasonable.
Q Tell us what distress she would have had.

Describe it to us, if she, so motivated, tried to stop in 1963 and 1964.

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A I think it's likely that she would have felt acutely uncomfortable. I think it's likely that she would have experienced strong cravings and urges to smoke. I think it's likely that she would have had difficulty concentrating, that she may well have suffered sleep disturbance, and that it would have been a -- she would have found herself reaching for a cigarette even when she didn't want to; that is, that it would have been extraordinarily hard for her not to smoke.

Q Is that any different than the distress that she experienced in 1947 when she, as you say, cut down?

A Well, indeed, because she didn't stop, she -- she used cigarettes in such a way apparently to minimize her distress. She -- so she reports having experienced some distress. I think she minimized it by smoking.

And also, I think that in '47 that her -- her potential for distress may have been less because she hadn't been smoking as long.

Q Was that distress that she would have experienced in '63 or '64 any different than the

distress she experienced in 1981 and '82 when she attempted to stop?

A That's hard to know. The situation was very different than '81 and '82 in that she was seriously physically ill and specifically had had a lung, first a part of a lung and then a whole lung removed as a result of smoking. And I think that would have helped her overcome that distress.

Q So you think the distress of stopping smoking in '81 and '82 was less than the distress that she -- during the time -- well, withdrawn.

You think that the distress that she personalized in '81 and '82, in your experience, was less than that what she would have experienced in '63 and '64; is that what you're saying?

A Let me be sure I understand.

Q Pardon?

A Let me be sure I understand that so I can respond to it.

Q Okay.

A That's hard to know. I think her distress may have been equal but her motivation was much higher. It would have had to be much higher in '81, '82.

Q If she had been advised in 1942 that there were health hazards associated with cigarette

smoking, let's say 1943 instead of '42, would she have been motivated to stop smoking?

A Let me just check where '43 falls in her smoking history.

Q Fine.

(Witness reviews.)

MR. DARNELL: When you ask that question, do you mean in the absence of any information that might be positive towards smoking, that's the only information out there, or that information plus whatever else we know there was about smoking in fact during that time?

MR. KEARNEY: Mr. Darnell, I am very used to your coaching the witness.

The Doctor may not be, so would you like him, to have that read back to him?

MR. DARNELL: Sure. Read it back. Because it wasn't coaching, it was a legitimate question about your question.

MR. SIRRIDGE: But you're not sworn in, Alan. No one cares whether you understand the question.

MR. DARNELL: His question does not mirror reality and, therefore, I think it's an appropriate objection to the type of question.

And if you don't like it you can stop the deposition but --

MR. SIRRIDGE: Well, then make the objection. It's just called objection to form. Is that a hard concept to understand, Alan?

MR. DARNELL: Apparently it is because I don't agree with your objection to form concept.

MR. KEARNEY: Let me just say, because this is going on a little bit too much, the magistrate in this case has expressed his views on how objections should be made. You may not be familiar with them because we just haven't worked very much together in the case.

And let me tell you, his view in essence is that he just wants objections to be stated, no argument, and he will not be happy if this is presented.

BY MR. KEARNEY:

Q Can we have an answer to the question?

A Can you read back the question because I'm lost now.

MR. SIRRIDGE: Read back the question.

(Question read back as follows: "If she had been advised in 1942 that there were health hazards associated with cigarette smoking, let's say

1943 instead of '42, would she have been motivated to stop smoking?")

A If she had been advised and truly believed it, I think she would have been motivated.

Q If she had -- let me add something because I think it's very important.

That in 1943 my understanding is that she initiated smoking in '42 and that there was a period of acceleration in 1943, so that's a very, what do I want to say, eventful period.

Doctor, do you know what she believed in 1942 about the health hazards of cigarette smoking?

A Let me consult my notes if I may.

(Witness reviews.)

A Her testimony regarding that period emphasizes the social attractiveness of smoking.

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She doesn't say much about any deep understanding of the health hazards, and so I think it's more likely than not that she didn't understand them well.

Q And that's your opinion in this case --

A Yes.

Q -- that she did not understand that there were health hazards with cigarette smoking in 1943?

A No. What I said was she didn't understand them

well. Again, I don't -- I don't think that belief and understanding are dichotomous, yes/no sort of concepts, particularly as regards to motivating behavior change.

Q Well, tell us what you believed and understood about the hazards of cigarette smoking in 1943.

A Well, I want to answer you accurately and so, again --

Q If you know, Doctor.

A -- go back to her deposition.

Q If you know.

A I want to answer --

Q Let me withdraw the question.

Do you know what Rose Cipollone understood and believed about the health hazards of cigarette smoking in 1943?

A Okay. It is my understanding -- again, let me say that I would prefer to go back to the raw data, as it were, so that I can give you an accurate answer.

But I believe that she was not fully cognizant of the -- of the health hazards of smoking at that time and indeed, very few people were.

Q What is the raw data that you just referred to in that answer that you would have to go

back to?

A I would need to look at her deposition and, you know, I've read literally thousands of pages of testimony. I would want to see exactly what she was asked and what she said about it so as to make my opinion as accurate as possible.

Q Other than looking at what she said in her deposition to -- let me withdraw that.

Is that the only way, Doctor --

A No.

Q -- or the only support for your opinions about what she believed and understood about the health hazards of cigarette smoking in 1943?

A No, it is not.

Q What other bases or support do you have? What other data do you have?

A The other kinds of information that would be relevant would be what information was generally available and believed by the public. That would be relevant.

Q Have you looked at that?

A Not closely, but it's my understanding that at that time there was very little widely known information about the health hazards.

Q What's your basis for that statement?

A Having interviewed very many smokers who started during that time would be one basis.

Q Anything else?

A Also, I know that even after there was obviously a lot more publicity about the people's understanding and belief and acceptance, it was still incomplete. And, therefore, it's a reasonable inference that when less public information was available, belief would have been even less.

And finally, that even after more information was -- was available, that teenagers in particular tend not to fully grasp and personalize that information.

Q In 1946 if she were told that cigarette smoking was bad for her health would she have been motivated to stop smoking?

A Let me just repeat that the issue of being told, it would depend very much on what she was told, how she was told and what she believed.

So from just being told, that's not -- that's not enough information.

Q If she was told that by her husband?

A It would depend very heavily on what she was told, how she was told it, what else, what other sources of information she was relying on, et cetera.

Q When the warning statement came on the cigarette packages in 1966, was that something that would have motivated Mrs. Cipollone or did motivate Mrs. Cipollone to try to stop smoking?

A I think at that time had she been able to fully grasp it, it would have.

However, as I've explained I think that she to some extent was unable to grasp that information and to personalize it, and indeed she found ways to rationalize it, to focus on other statements that made the information questionable.

And that was in part because realizing how dependent she was on smoking made it psychologically difficulty to grasp and accept that information and personalize it.

Since she felt incapable of acting, it was hard for her to grasp the information that would have motivated that action.

Q In 1947 was she capable of personalizing, grasping and accepting a health message about cigarette smoking and lung cancer?

A To some extent. Not completely.

Q She was not; correct?

A No, I didn't --

Q She was --

A I said -- I'll say again that I think that these things are matters of degree, and except by a slip of the tongue I'm not going to be able to give a yes or no answer.

Q Now, when you say they're matters of degree, explain to us the degrees by which you characterize -- quantify the characteristic of being unable to personalize information. Explain the degrees to me.

A I don't grasp the question.

Q All right. You say it's a matter of degrees --

A Yes.

Q -- the extent to which somebody can personalize a health message.

A Right.

Q Right?

I want you to describe for us what those degrees -- how do you characterize those degrees?

A Well, for example, one might be aware that some people say smoking is harmful to you but have doubts about it. That would be one degree.

One might, for another example, even believe that smoking is harmful to some people but not believe it about one's self. That would be another

degree.

One might think that the risk to one's self is very small.

The ultimate would be I suppose to realize that you personally are going to die as a result of smoking.

And I believe when she had that realization she did quit.

Q And what are the degrees -- is it the same -- other than these kind of anecdotal things you can't give you. I'll withdraw that.

A Thank you.

Q What are the degrees of grasping and acceptance?

You said those are a matter of degrees. Explain that to me.

A That is what I was trying to explain.

Q Okay. Same as the personalizing stuff?

A Well, actually let me add something because there is more in there.

Part of that process is also making the information very specific and concrete.

So, for example, when you talk to people they can sometimes describe to you that smoking is bad for them, but they're unaware or haven't fully grasped

that it causes lung cancer, how fatal lung cancer is and so on.

So those are -- that's a level of detail that gets filled in as a person moves through that process as well.

Q By the way, Doctor, people can quit smoking without having grasped, accepted and personalized a specific health consequence of smoking to them; isn't that right?

A For dependent smokers that would be very unlikely.

Q Can dependent smokers stop smoking?

A Yes.

Q Have dependent smokers ever stopped smoking?

A Yes. Some dependent smoke --

Q And stop smoking permanently?

MR. DARNELL: Excuse me. One at a time. You're stepping on his answer. Please let him finish.

You want to repeat the question, please?

Could we hear the question again, please, because I think we -- we've been hearing two channels at once there.

Q Do you agree with Dr. Jaffe when he said that dependent smokers can stop smoking?

A Yes, I believe some dependent smokers can stop smoking. Indeed Rose Cipollone stopped smoking when she was dying.

Q Do you agree that millions of dependent smokers have quit smoking?

A I believe millions of smokers have quit smoking and I believe many of them were dependent.

Q Do you believe that millions of dependent smokers have stopped smoking? And I'm going to ask you to answer the question.

MR. DARNELL: Well, I think he did but -- now you can answer it again.

A Okay. I want to be careful.

There are no studies that have assessed the dependence of those smokers who have quit.

There are studies that show that those who are able to quit are generally less dependent or not dependent.

Nevertheless, I'm trying to be clear and responsive. Many people, indeed millions have quit and many of those are likely to have been dependent.

A dependent smoker was less likely to quit. And I don't know of any firm data on the percentage of those people who are dependent, except to say that it's the less dependent people who quit

and are successful at quitting.

Q Now, all these people who quit, does every single one of them -- has every single one of them personalized, grasped and accepted the health consequences of cigarette smoking?

A I believe many or most have.

Q All right. Is it possible, possible, that one of them did not personalize, grasp and accept the health risks of cigarette smoking?

MR. DARNELL: Was that meant to be a serious question?

MR. KEARNEY: Sure it is. Absolutely it is.

A I believe that for a dependent smoker to successfully quit smoking they would need to have a very compelling personal motivation which typically would be having to grasp the health risks to themselves.

MR. DARNELL: Can we just hold it up for a second.

(Interruption for phone call.)

Q You think that that's necessary in order to successfully quit?

A Some intense motivations, yes, I do.

Q All right. Would you -- would it be fair

to say that in order to quit the motivation to quit has to be greater than the motivation to continue smoking?

A It's not how I would characterize it.

I'd say there has to be great motivation but it's not -- are you counting dependence as a motivation to continue smoking?

Q I'm counting a craving, desire, wish, want.

A Dependence, if we count dependence then I do think the motivation has to be stronger than the motivation to continue.

Q Let's not count dependence.

Do you think the motivation to quit has to be stronger than the motivation to --

A That's an unanswerable question because dependence is an important part of the motivation. It's the major motivation to continue smoking.

Q Okay. So am I correct that you believe that in order to successfully quit a dependent smoker has to have personalized the health aspects or consequences of cigarette smoking; is that correct?

A Or to have otherwise developed very intense motivation.

Q Intense motivation outside of health

concerns; is that right?
A That's possible.
Q So they've got to know, in order to quit they've got to -- specifically what do they have to know in order to quit?
A Again, I want to be sure that I'm making myself clear that it's not just a matter of knowing, but rather of personally realizing not only cognitively, but to some extent emotionally that they personally are at risk, that they may die.
Q And that's -- that is all they've got to know --
A No.
Q -- in order to be able to be motivated to quit?
A I didn't say that.
Q Is that correct?
A I didn't say that.
Q Well, what is it that they have to know and accept, Doctor?
MR. DARNELL: Again, Counselor, you're cutting him off in the middle of an answer. Please. You're not letting him finish his answer.
Were you finished?
THE WITNESS: No.

A Again, I'm uncomfortable with your characterizing it as knowing as though it were something you simply read on a page.

I think it's a direct personal realization that then becomes motivating. And that includes the realization of personal risk in detail. That is the most common and important motive for quitting smoking.

Q Tell me, if a person knew that the lifetime risk of them getting lung cancer from smoking cigarettes was 1.4 percent, would that be sufficient to motivate them to stop smoking?

A Again, let me reiterate I think the key issue would be whether the person experiences a direct personal sense of risk and harm.

If that -- if a person was able to grasp from that information that they were personally at risk and might die of lung cancer, then that could serve as a motivational basis for getting them to quit smoking.

You know, of course, too, that heart disease is, if anything, more common in people who are smokers. So that information would play an important role as well.

Q If a person were told that there was a

five percent chance that they would get lung cancer, that they would get lung cancer from the cigarette smoking after a lifetime of cigarette smoking, would that in your opinion be sufficient to motivate them?

A Only if it led them to feel personally at risk.

Q And you have no opinion on what is necessary to lead a dependent smoker to conclude that they are personally at risk; is that right?

A No. I didn't say that.

Q All right. Well, then answer my question.

A I thought I did.

Q If a dependent smoker were told that there was a five percent chance that they would get -- that they would get lung cancer from a lifetime of cigarette smoking --

A Uh-huh.

Q -- would that be sufficient motivation to -- or would that be sufficient information to lead to what you call personalized motivation to quit?

A It would depend on how the information was presented, the degree of certainty and, again, while you're focusing on the absolute risk of lung cancer, I think there's other information such as the relative risk and the risk of heart disease and, again, the

degree to which the person absorbed the information and found they themselves personally to be at risk.

So for example, if someone believed that smoking low tar and nicotine cigarettes shielded them completely from that risk, then telling them that information would not be sufficient if they could then say well, yes, that's true for those people over there, but not for me.

Q Could you, Doctor, or rather when you quit did you personalize health information?

A Uh-huh. Yes.

Q And what was your understanding of the health risks of cigarette smoking when you quit?

A I had a -- what I think was a -- a fairly deep and sophisticated understanding of them since I was by that time studying the field, and I came to realize that it was likely I would die as a result of smoking if I continued.

Q What would Rose Cipollone need to have been told, and by whom, in 1963 to sufficiently motivate her to stop smoking?

A In '63. She would have had to have an unambiguous message; that is, not a mixed message that some people think that smoking is bad for you but others don't and we're not sure.

So the message would have had to have been unambiguous and in essence -- that's the unambiguous. She would have had to be told that her smoking in particular put her at risk.

Let me recall what she was smoking in '63. That even though she had switched to filtered cigarettes at that time, that that did not protect her. And again, she would have had to hear that unambiguously, clearly, not a mixed message.

Q So she would have to be told -- withdrawn.

The message has got to be unambiguous, but I don't know that you've told us what the message was.

What message had to be unambiguous that would have motivated her to try -- to quit smoking?

A The message would have had to be that it was likely that she would lose health and life as a result of smoking as she was smoking.

Q And had she gotten that message, it's your opinion that more probably than not she would have been motivated to quit and she would have quit?

A Let me try to respond to that as best I can.

Firstly, I think the way you characterized it I just want to amplify that had she

gotten the message, that is, gotten it in the sense of grasped it and personalized it, she would have been motivated.

And indeed at that time I think she was motivated. She reports that she tried to cut down. Again, that was based on an understanding that cutting down would protect her.

Had she -- it would have made it more likely that she would have quit had she been able to grasp her personal risk and overcome her belief that she could -- that she was protected by, whether it was smoking filters, cutting down, et cetera.

Q It's your understanding that in the 1960s she believed she was protected from risk by smoking filtered cigarettes?

A I think that's more likely than not.

Q Did she believe -- did she believe during that whole period of the 1960s that she was protected completely, by that I mean from all risks and health hazards associated with cigarette smoking?

Is that your understanding?

A No. I didn't say completely or from all risks.

Again, these are matters of degree and to the extent -- it's -- parts of the process are analgous to a legal process.

If she had in her mind issues which raised reasonable doubt, if you will, that would have made her not believe it as well and she would have experienced some protection.

Q All right. Tell me, just so I understand it, it's your testimony that in the '60s she believed that smoking filters reduced her risk but didn't eliminate it; is that right?

A I think it's likely that she experienced some sense of protection from the health risk by virtue of smoking filters.

Q So she understood that there was still some risks. Is that what you're saying?

A Let me come back to it's a matter of degree of belief.

And you're trying to separate what she believed and make her believe one thing with certainty and another one weakly, and I am trying to characterize belief as a matter of degree.

Q All right. I'm not concerned about the degree of belief.

A I am.

Q I'm concerned about the object, okay.

Did she believe, Doctor, that by smoking cigarettes she eliminated all risk or she just reduced

the risk? And I'm not asking a question about degrees of belief.

MR. DARNELL: Smoking? I'm sorry. I missed something.

What kind of cigarettes? Filtered cigarettes? I missed something in the question. Can I hear it again, please

MR. KEARNEY: I'll restate the question.

Q Did she believe in the 1960s that by smoking filtered cigarettes she reduced her risks or did she believe by smoking filtered cigarettes that she eliminated all risks of cigarette smoking?

A I don't think that that's a distinction she would have made, and I see that as part of the matter of degree that we are talking about.

Q I guess I'm asking you the question, though. Mrs. Cipollone is not here to ask her that question.

A I understand that.

Q Is your opinion --

A You are asking me to characterize her belief, and that's what I'm doing. I'm saying that her belief was a matter of degree and acceptance of those beliefs.

You're asking me to characterize her, not

what I believed in '63.

Q Had she been told in 1953 --

A '53?

Q '53, yes.

A Okay.

Q -- that it had not been proven that cigarette smoking caused lung cancer but there was a suspected link, would that have motivated her to try to stop smoking?

A I think it would have had some motivational relevance, but I think, in fact, the way you phrased it would have tended to diffuse its motivational relevance, particularly in light of her dependence at that time.

Q By diffusing its motivational relevance could you --

A It would reduce --

Q -- what does that mean?

A It means it would reduce the degree to which the information was relevant, was motivating.

Q By reducing the degree to which the information was relevant, what does that mean?

A No. I mean it would reduce the degree to which the motivation -- the information was motivating given that it is -- the statement you made is stated in such

an ambiguous way.

Q So it would have made it less likely that she would have quit if she were told that; is that right?

A As opposed to being told that she, you know, that she was at risk that there was substantial evidence? Yes, if you say yes, there may be some risk.

Q Would that have increased the likelihood that she would quit?

A Would what have?

Q Let me withdraw that. Let me withdraw that.

That type of a message, Doctor, would that increase the likelihood that she would quit over no message at all? Do you understand my question?

A Yes. In other words, if everyone was going around saying smoking is absolutely not bad for you.

Q Nobody was saying anything at all.

Would a message that it has not been proven that cigarette smoking caused lung cancer but there is a suspicion of a link between cigarette smoking and lung cancer, would that have increased her -- well, I'll withdraw the question. I'm even confused.

A Good thing.

Q In 1955 if she were told that cigarette smoking should be viewed with suspicion as a possible caus --

A Can I raise something?

Q Causative agent. Let me finish the question.

-- as a possible causative agent of lung cancer, would that have increased --

A I'm sorry. I didn't hear it.

Q As a causative agent of lung cancer, would that have increased -- would that have motivated her to try to stop smoking?

A Relative to what?

Your earlier question was relative of -- relative to there being no information.

Q Well, you know what information she had in the '50s, right?

A No.

Q You don't?

A Not in detail.

I'm confused because there are two questions you asked.

One was relative to there being no information and now you're saying relative to what was

actually out there.

Q Relative to what was actually there. Relative to what you understand was her awareness and belief with respect to cigarette smoking and risk of cigarette smoking.

A I'm really sorry, but I'm -- now I'm lost.

Q Okay.

MR. DARNELL: Let the Doctor go to the men's room.

We'll take a few minutes, five minutes and we'll resume.

(Recess taken from 3:50 to 3:55 p.m.)

Q What would Mrs. Cipollone have to have been told in the '50s, in the period of the 1950's in order to have motivated her to try to quit and successfully quit?

A What's the period again?

Q 1950's.

A Okay. All of the '50s?

Q Right.

A Because a lot happened during that --

Q Pardon me?

A Because I assume --

Q You can break that period up if you choose to. If it's relevant to your answer, go right

ahead.

A All right. I think she would have had to have been told that it was likely that smoking was dangerous and that it might be linked to lung cancer. That she might -- there was some reason to believe she might get lung cancer as a result of smoking.

And I think it's also relevant, you're asking me what she -- that would have to be told to her in the absence of information saying that it's probably not risky, in the absence of information portraying it as not risky.

In other words, it's not just what one message is but the context I talked earlier about mixed messages.

Q It would have to be unambiguous; correct?

A Yes.

MR. DARNELL: Off the record.

(Discussion off the record.)

Q Would have to be unambiguous, right?

A It would have to -- it would have to be an accurate representation of the scientific evidence. It can't -- wasn't to be made up based on what was unknown at the time.

Q But if the scientific evidence was itself ambiguous would that be sufficient to have motivated

her to quit and -- motivated her to try to quit and quit successfully?

A I'd need more information about exactly what the state of the science was at the time.

That's really not my -- my area of expertise. If you --

Q Okay. So what you just told us, however, would not be sufficient to motivate Mrs. Cipollone to stop smoking in the '50s?

A I'm sorry. I lost the reference.

Q I'll give you the reference.

Okay. You just said that she would have been motivated to stop smoking, to try to quit and she could have quit successfully had she gotten an unambiguous message that smoking was likely to be dangerous, might cause lung cancer, and that she had reason to believe that she might get lung cancer.

A What are you asking?

Q All right. That's what you told us.

Now, would that have been sufficient to motivate her to try to stop smoking and to quit successfully had there been other information available in the newspapers that created ambiguity about the health risks of cigarette smoking?

A I think it -- okay. I think the ambiguity

would have tended to weaken the message.

Q So that if she was told in '53, for example, that it had not been proven that cigarette smoking caused lung cancer, that would increase the ambiguity and make it less likely that she would be motivated to stop smoking; is that correct?

A It depends to some extent on the balance of what she was told and what reassuring and doubting messages she was getting along with messages that she was getting about the risk, and also would have to do with the degree to which she personalized it.

Q Now, do all dependent smokers who have successfully quit smoking, have they all received and accepted an unambiguous message of cigarette smoking and health?

MR. DARNELL: I'm going to object to that because I think that was asked and answered oh, about 45 minutes ago.

MR. KEARNEY: What was the answer, Alan? I don't remember.

MR. DARNELL: I'm not going to portray it, but I do remember the question.

You can answer it again.

A Okay. I think it's likely that many of them would have accepted that information and personalized

it in some way.

I couldn't go to the degree of certainty that you're asking for, which is that all of them have.

Q Okay. So --

A And what time period are we talking?

Q I'm talking say in the 1950's, for the dependent smoker who stopped smoking in the 1950's was it necessary for them to be -- to be sufficiently motivated to quit that they received an unambiguous message about the health consequences of cigarette smoking?

A It would have been one element in the equation, but one would have to look at their degree of dependence, other motives they may have had for quitting.

Q So it's not -- the ambiguity of the message is not essential or necessary to create motivation, sufficient motivation to quit?

A I lost you because you're saying ambiguity.

Q You keep saying that Mrs. Cipollone needed an unambiguous message, right?

A That's correct.

Q And I'm asking you in your opinion do all dependent smokers in order to stop smoking need an

unambiguous message? Is that your opinion?

A I think to be motivated, dependent smokers need to come to accept their personal risk.

Again, that has to be weighed against the degree of dependence in that getting an unambiguous message is part of the process leading them to accept it. It's not the only thing.

Q So that what you're saying is that people who get an unambiguous message can still be motivated to quit?

A An unambiguous message?

Q An ambiguous message can still be motivated to quit, right?

A They might be able to work their way through the ambiguity. It would be less likely than from an unambiguous message.

Q When you say "work their way through the ambiguity," what do you mean?

A I mean that they might -- well, let me give you an example.

As given my training I'm more able to evaluate statistical ambiguity and statistical risk information, and I -- therefore, I'm gonna have better -- be able to better reach a conclusion from ambiguous premises.

Q Isn't by its very nature statistical risk information ambiguous?

A It's uncertain.

Q And uncertain means ambiguous; correct?

A I'm uncomfortable characterizing it that way. That there's a point at which statistical evidence is enormously compelling even though it is not the same as nonstatistical direct evidence.

Q Well, the message cigarette smoking, a lifetime of cigarette -- smoking cigarettes, a risk of five percent chance of lung cancer from cigarette smoking by its very nature that's an ambiguous, uncertain message, isn't it?

A No. It seems to be a pretty clear statement.

Q The message cigarette smoking might cause lung cancer, is that an ambiguous or an unambiguous message?

A That could be construed as an ambiguous message. It doesn't --

Q Cigarette smoking might be a cause of lung cancer, is that an ambiguous or an unambiguous message?

A Let's say it is more ambiguous than saying cigarette smoking is a cause of lung cancer.

Q Would you characterize it, however, as an

ambiguous or an unambiguous message?

MR. DARNELL: If you can answer it that way, answer it.

A Yeah. Again, I'm trying -- you're acting as though that is unambiguous, that things are ambiguous or not usual. There are degrees of uncertainty in ambiguity.

Q In 1964 if Rose Cipollone was told that she had a 98.6 percent chance of not getting lung cancer from a lifetime of cigarette smoking, would that have been an ambiguous or an unambiguous message to her?

A Let's say it would have communicated -- it would have tended to minimize the sense of risk that might have motivated her to quit smoking; that is, it would have emphasized the positive.

It would not have talked about relativeness, would not have talked about other diseases.

I'm not -- does that answer your question? I'm not sure.

Q Let me ask you this question: If a dependent smoker gets the message that I might get cancer from my cigarette smoking and I might not get cancer from my cigarette smoking, is that an ambiguous

message?
A That has some ambiguity in it. The degree of ambiguity would, again, depend on other information such as --
Q Internalized and personalized, would that be sufficient to motivate a dependent smoker to try to stop smoking?
MR. DARNELL: I'm sorry. I don't know if that was a question.
Can I have it read back, please.
(Read back.)
MR. DARNELL: Objection as to form.
I don't know what's internalized or personalized --
Q I meant to use your terms, personalized, grasped and accepted. I adopt that modification.
A To the extent that the person interpreted that as representing a risk to them and didn't dismiss it, then that would help motivate them to change their behavior.
Q Let's go on.
How would you describe Rose Cipollone's personality, Doctor?
MR. DARNELL: Time frame.
Q Did her personality change over time?

A Actually people describe her as fairly consistent.

Q Do you need a time frame to answer that question fully and completely?

A Well, may I reserve that?

Let me try to describe it and maybe we can move forward.

Q Okay.

A She -- there seems to be some consensus that she was outgoing, that she was loving, that she was sociable, that she was strong-willed.

That's how I would characterize her personality.

Q Intelligent?

A Hard to say. Reasonably so.

Q Pardon me?

A Reasonably so.

Q What do you base your --

A I have no reason to think she was dumb.

Q Well, in coming to your opinions in this case was it important to you to arrive at a conclusion as to her degree of intelligence?

A It was somewhat relevant.

For example, I think she was able to answer questions reasonably and to understand them.

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You know, I had no -- sometimes if you read an interview and it's clear the person's intelligence doesn't allow them to give reasonable responses, you -- I would tend to discount their responses.

She seemed by and large, with some exceptions, to grasp the questions that were posed to her. She -- I didn't look at this closely, but her vocabulary seemed reasonable.

I was -- I would describe her I guess as reasonably intelligent and also relatively unsophisticated.

Q And you describe her as relatively unsophisticated right through to 1981?

A Yeah, I think so.

Q What do you mean by "relatively unsophisticated"?

A I'm attending in part to her education which was not that substantial, certainly by today's standards.

Again, although I think she was able to respond to the questions, her responses don't -- you know, reflect some lack of sophistication. She sometimes had to ask what words meant or her word use was not that rich.

Some of the -- I'm making an inference from the family's blue collar background to some extent. I am aware that she read a fair amount.

Q Would you agree that there was no cognitive impairment of her logic? There was nothing wrong with her brain?

A In what area?

Q In any area.

A With her brain?

Q Right.

A You mean organically if we went in would we find a lesion of some sort?

I have no reason to think we would.

Q And what about cognitive impairment in her logic? Do you agree that's not evidence of any cognitive impairment in her logic?

A That gets more complicated because many of us have trouble thinking logically about matters that are difficult for, us and I think that was probably true of her. So -- I wouldn't describe that as a brain dysfunction.

Q What's your basis for saying that she was strong-willed?

A I'm basing it very much on the reports of family members.

Q Was she a trusting individual?
A I think -- I have some sense that she was trusting of authority.
In fact, that's part of what I even -- suppose that's part of what I think as unsophisticated. At least today we are much more -- much less trusting of authority.
Q Is there some way a psychologist has of testing whether a person is a trusting individual?
A I think there are standardized tests for that and --
Q Have you ever given one of those standardized tests?
A No. It's not a question that's typically posed in a clinical situation.
Q Is it -- but there are tests available for it?
A Uh-huh.
Q Give us the name of some tests available for it.
A I would need to consult references. I don't carry with me in my mind the name of every test.
Q Okay. Well, tell us what information those tests seek in order to make a determination about whether a person's personality is a trusting

personality.

A I would need to look at them carefully.

Again, I'm aware, and even not with perfect certainty, that they exist. They have -- I'm not aware of any clinical use for those tests, and so I'm not intimately familiar with them.

Q So you can't name them and you've never used one; correct?

A That's correct.

Q And you can't tell us now what information is elicited by those tests in order to determine whether or not a person is a -- has a trusting personality; am I right?

A Right. I can't tell you what right now.

Q What's your basis for saying she was trusting of authority?

A She described, in fact, in her deposition -- maybe I better find it.

Again, I want to be very careful not to misrepresent her -- her -- she gave information relevant to her trusting -- trustingness.

Q So is it correct that your only basis is something that she said in her deposition for coming to the conclusion that she was trusting of authority?

A Some of it is based on -- for example, she

describes -- it is based on information from hers and other depositions. It seems as though she was trusting of authorities.

Q Now, what do you mean when you say "trusting of authorities"? Tell us what you mean by that.

A Well, for example, she stated that she didn't think that the government would allow tobacco companies to sell a product that was dangerous.

So she had a sense somehow that this larger authority would protect her, and indeed she had the same view toward the tobacco companies themselves.

Q Did she view the tobacco companies as authorities?

A Yeah. As public institutions.

Q And she viewed -- and she viewed the government as authorities?

A I believe she did, yes.

Q So did she -- withdrawn.

Anything else?

What else do you mean with respect to trusting authorities, that she trusted the government and tobacco companies?

A Again, part of my inference is from her background both in terms of education, where she grew

up and so on, and the times, that she would have very likely been trusting.

Q Did she trust all companies?

A Oil companies?

Q All companies.

A I'm sorry.

MR. DARNELL: Off the record.

(Discussion off the record.)

THE WITNESS: Are we back on the record?

BY MR. KEARNEY:

Q Did she trust all companies?

A It's very hard for me to judge that because what was elicited in depositions and interviews didn't really elicit that information.

Q I thought you told me part of her personality was that she was a person trusting of authorities?

A Right. I think she would have been predisposed to trust large companies, yes.

Q So she trusted her teachers in school?

A I would think she would have been predisposed to respect them, yeah.

Q Was she predisposed to trust the Surgeon General of the United States?

A Oh, I think she probably was. And that's --

Q Her mother?
A Her mother? Certainly she would have respected her. Whether she would trust her as an authority on certain things is less clear, because in certain cultures mothers are not seen as authorities on worldly matters.
Q Are you aware of how mothers are perceived by their daughters in the culture in which Rose Cipollone grew up?
A As -- I would -- I would venture a guess that she respected her mother, but it seems to me plausible that she would not have trusted her as an authority on science, for example.
Q I'm asking you a different question.
I'm asking you, are you an expert --
A Am I an expert on that? No.
Q -- on the culture?
A I am making a reasonable inference of the sort that clinical psychologists make all the time.
But am I an expert on the Italian American culture? No.
Q In the 1940s?
A No. I'm not an expert on that.
Q Have you ever studied how Italian American daughters viewed their mothers in the 1940s?

A Studied in the classroom? No.

Q Studied in the classroom; in a library; done any research on it?

A No.

Q Research any articles on it?

A Clinicians reasonably rely on broad cultural information and on experience with clients on -- we draw on much of the same information a layperson has.

So again, to be clear, I'm not an expert on that.

Q Why did Mrs. Cipollone start to smoke?

A Why did she start? This is in '42.

I think that she saw it as glamorous and sophisticated. And as many -- that's, in fact, the reason very many people even today start smoking.

Q Did she -- tell us why she continued to smoke right away.

A I need a time frame there.

Q Pardon me?

A I do need a time frame to answer that.

Q Okay. 1943 to '47.

A Let me answer it this way: I think there was a shift in her reasons for smoking.

So when I say that she started smoking in order to feel sophisticated, I don't mean that that

accounted just for her first cigarette.

Rather, the way I see it that those motives were dominant early in her smoking career. They faded in importance to be replaced by motives to do with dependence.

She stated in 1943 that she was beginning to develop a need to smoke. Those are her words she stated in 1946. She stated that in 1946 she found it hard to stop.

So in my judgment motives related to dependence and compulsion increased in prominence during the period that you're asking about.

Q Why did she choose Chesterfield cigarettes to smoke in 1942, '43?

A Again, I want to give you an accurate answer so I want to be sure I don't misrepresent her.

May I look at her deposition? Do we have the right volume here?

No, we don't.

MR. DARNELL: Which one do you need?

THE WITNESS: I need the volume that has pages in the low hundreds, like 120s.

(Recess.)

THE WITNESS: Thank you.

(Witness reviews.)

A This confirms what my -- my initial impression. She thought Chesterfields were glamorous based on some ads that she'd -- again she reports, and since she also perceived certain other brands, I believe she reports that she saw Lucky Strikes as being masculine and for men.

That wasn't the image to which she aspired and so she -- she chose Chesterfields based on their image of glamour, which appealed to her.

Q In the 1940s did she have any perception at all of any health risks in connection with her smoking cigarettes?

A Again, let me be sure -- I believe that she had a very minimal perception.

Q But she had some perception of health risks; am I correct?

A Mostly as I recall -- well, let me -- not as I recall. Let me try to answer you accurately.

(Witness reviews.)

Q I see you're going through your notes in order to shortcut that.

You're going to have to read through all your notes in order to answer that question?

A No, not all of my notes.

Q Go ahead.

A Again, I want to respond to you accurately.

And since it's very much based on her report as well as something about the environment, I want to not misrepresent her.

(Witness reviews.)

THE WITNESS: Alan, I'm afraid I am going to have to use you as a runner again.

MR. DARNELL: No problem.

THE WITNESS: Pages in the low 500s.

MR. DARNELL: I'll bring them all in.

MR. KEARNEY: I'm going to withdraw the question, Alan.

Let's proceed with the deposition.

MR. DARNELL: Okay.

BY MR. KEARNEY:

Q Am I correct, Doctor, that the only basis that you have for an opinion about what Rose Cipollone knew of health risks associated with cigarette smoking in the 1940s is what Rose Cipollone said in her deposition?

A No. I think that that is very important, but I think --

Q What other information do you have about Rose Cipollone's perception of health risks of cigarette smoking in the '40s other than her

deposition?

A It's my understanding that most people in her situation would not have been well informed about the health risks.

Q Would most people -- I didn't mean to cut you off. Go ahead.

A It's -- where was I?

Q You said that most people in her situation would not be well informed about the health risks of cigarette smoking.

A Right. And, again, also that most teenagers then and today would not -- would tend not to grasp and personalize the health information.

So I base it on those as well, but I would -- I would like to, if you want me to respond more fully to the question, to try to use the information that she gave as well.

Q Now, you said most people were not well informed.

A Uh-huh.

Q Most people in her situation.

What were most people in her situation informed about -- whether they were well informed or not, what was it that they were informed about the health risks of cigarette smoking in the 1940s?

We're talking from '43 up to '50.
A I think I would guess that people had a vague sense that it might be bad for you.
Q Let me ask you this question: Did most people in her situation believe that cigarette smoking was safe?
A I think they thought it was relatively safe, yeah.
Q But did they think it was entirely save, that smoking a lifetime was safe?
A That would be hard to say.
Q You don't know?
A It's -- I don't know.
Q You mentioned -- did Rose Cipollone smoke, by the way, for pleasure at any time in her life?
A What do you mean by that?
Q Did Rose Cipollone at any time in her life smoke for the pleasure of smoking?
A To answer that we would need to analyze the pleasures of smoking.
Q Okay.
A So --
Q You can't answer that just by the use of the word pleasure?

A Well, I think it gets very complicated and I would hate for you to have a different interpretation than I do about what that means.

Q No. We're, again, fine just as long as at trial when I ask you the question about Rose Cipollone smoking for pleasure your answer is going to be the same.

MR. DARNELL: It depends on how pleasure is defined.

Q You're going to ask me for a definition of pleasure?

A What I'm saying is, let me give you firstly, Dr. Dunn from the -- from Philip Morris made a statement with which I agreed; which is that people's -- smokers self reports of what they get out of smoking are sometimes erroneous.

And I think that's particularly true when people attribute their smoking to vague motives like pleasure.

Q Was there anything that Rose Cipollone --

MR. DARNELL: Excuse me. I don't think he was finished. He was trying to answer your question. Please let him do so.

Continue, please, Doctor.

A In my experience sometimes when people say they

smoke for pleasure, what they mean is that if they're uncomfortable perhaps because of withdrawal it feels better after they smoke.

And I think that's not -- that may not be what you meant by smoking for pleasure, and so I want to be careful, for example, to distinguish those.

Q Did she smoke for taste?

A Again --

Q You can't answer that question either?

Did she enjoy the taste of cigarette smoking?

A Again, with lots of repetition she may have come to enjoy it. I wouldn't count that as a major motive for her smoking.

Q Did she ever enjoy the taste of a cigarette?

A It's possible that she did.

Q Did she ever enjoy the aroma of a cigarette?

A It's possible that she did.

Q Did she ever enjoy smoking cigarettes?

A It's possible that she did. Again, especially relative to not smoking cigarettes.

Q Did she ever smoke for relaxation?

A Can you clarify what you mean by that? Because

that really is ambiguous.

Q Did she smoke -- let's -- you need a definition of relaxation in order to answer that question?

A At least in the area of smoking that word is used in several different ways and, again, I don't want us to misunderstand each other.

Q Doctor, I just want to get back to your -- the opinion that you gave us earlier this afternoon and see if I can complete some examination on the remaining components of that.

A Okay.

Q Among other things you testified that it's your opinion that she had an impaired ability to act flexibly with regard to smoking.

A That's right.

Q When did she get this impaired ability to act flexibly with regard to smoking?

A Let me say again that I consider flexibilty, like these other things, a matter of degree rather than a yes or no.

So her flexibility was somewhat impaired I would say in '47, and probably became more so later.

Q Not before '47?

A It's possible, but the evidence isn't that

clear.

Let me make a distinction which I think is gonna be important for us between what was actually the case and what we're able to learn from debriefing her retrospective history.

So I'm not saying she wasn't -- I'm saying the data trail isn't strong -- doesn't permit as strong a conclusion as in '47.

Q Let me ask you this question: Are you going to testify at trial that she had an impaired ability to act flexibly with regard to smoking prior to 1947?

MR. DARNELL: I think that's an improper question as to what he's going to testify to.

Q Is there enough information, Doctor, for you to come to a conclusion, and have you come to a conclusion on whether or not she had an impaired ability to act flexibly with regard to smoking prior to '47?

A I think it was beginning to become impaired.

She states that she needed to smoke. She states that it was hard to stop. So from '47 there was some -- there's some fragmentary evidence building up suggesting that her ability is starting to become impaired. The evidence becomes clearer in '47.

Q Did she try to quit or cut down prior to 1947?

A Not that I know of. I don't think so.

Q Okay. What is the degree to which she had an impaired ability to act flexibly with regard to smoking?

MR. DARNELL: At what point in time?

A I don't understand. Never mind time frame, I don't understand the question.

Q All right. Maybe I ought to start with this: Describe for us the ability to act flexibly with regard to smoking.

A Let me try and do that.

For most of us most of our behavior is fairly flexible; that is, many of the things we do, you might say using lay language, that we can take them or leave them.

It also means that our behavior is effected -- is often effected by cues and by incentives.

If I may give you an example. You've had a cup of coffee, but I suspect that if someone had said, let me give you a lot of money not to drink that cup of coffee -- although I don't know that -- you might well have said, no problem, I'd rather have

$1,000 than drink this cup of coffee; that is, you can take it or leave it. You are able to respond flexibly.

Similarly, if there was a rule here that you could not drink coffee, you might not suffer duress, you might be able to stand it, you wouldn't decline to attend the deposition on that account. So it shows that you're flexible, you can respond to social cues, to incentives to other -- other goods and organismic drives that you have.

A person losses flexibilty when the ability to respond to those different controlling cues is diminished and they're, in essence, increasingly flexible about their behavior. It becomes stereotyped, takes on a compulsive character.

I think I've answered your question.

Q Does any smoker have an unimpaired ability to act flexibly with regard to smoking?

A Yes, I believe so.

Q Pardon me?

A I believe that some do, yes.

Q Could you describe those smokers for us?

A Certainly I will and try to be accurate.

In fact, I think that many of us know such people. I know I've encountered people who may

smoke at a party, but if you tell them not to smoke they don't bat an eyelash about it, they simply won't do it.

If you -- they certainly would not weigh it, their opportunity to smoke, for example, into whether they're going to go to a party or not. It's simply they can take it or leave it.

And that would be an example of exercising that take it or leave it, flexible attitude toward smoking.

Q All right. What's your basis for saying that Rose Cipollone had an impaired ability to act flexibly?

A Because in a number of respects she -- she does not display the kind of behavior I've just described.

So for example, she would cut her visits to her daughter's short, the daughter reports, because her daughter didn't permit her to smoke in the house. That speaks exactly to the kind of example and concept I've just given you.

She did things which, for example, were uncharacteristic of her in order to salvage her smoking. She would hide cigarettes. She was unable to respond to her husband's urgings.

You know if, if my wife didn't like me to

talk loudly on the phone, which it happens she doesn't like, I have no trouble moderating that behavior.

In contrast, in the case of Rose Cipollone, in the face of what seems to have been a very intensive lobbying, if you will, by her husband, she was unable to respond to that cue.

Another example of an incentive is her husband offering her fur. I'm not a big fan of fur, but if someone offered me something valuable to give up a behavior that I could take or leave, not only would I do it, but it would be no conflict and it would be easy.

Another example which I think is actually quite telling, is that even after she had part of her lung removed she continued to furtively smoke some of the time. That shows the degree to which her behavior -- she'd lost ability to respond to some extent to cues.

And again, I think that that may well have been progressive throughout her smoking career.

Q How do you know that she just didn't want to -- she just didn't want to tell her husband and her doctor or let them know that she wanted to take a few cigarettes a day --

A It's clear --

Q -- what's inflexible about that?
A It's clear that she didn't want them to know.
Q Right.
A But she also -- well, for example, she describes for herself that she felt guilty about it.

So it shows that she found herself in the position of acting, in effect, against her own values, against her own goals and aspirations.

Q What's your basis for saying that she was unable to respond to her husband's constant lobbying to stop smoking?
A She said so. She said that it was very difficult and, in fact, she -- she was unresponsive.
Q Is it the case that every spouse who does not stop smoking in response to urges of their spouse is unable? Did it ever occur to you that somebody might be unwilling in that situation to respond to their spouses entreaties?
A I tried to give you several examples because the way one makes a judgment about these things is configural; that is, one has to weigh the pattern of the evidence.

So if she had been able to respond to things other than her husband's urging I would say well, you know, she wanted to tell him where to go.

But the -- let me finish. So I tried to give you several examples from several domains because the way a judgment is made is configural in that sense; that is, you look at a range of behavior.

Q All right. What's your basis for saying that she was -- what's your basis for saying that the reason that she did not abide by her husband's urgings to stop smoking was -- withdraw the question. I'm going to do another one.

You have determined that she was unable to respond to her husband's entreaties?

A She had difficulty.

Q She had difficulty?

A And she had lost some flexibility.

Q And it was not that she was unwilling?

A Again, let me explain that that is complicated, because to some extent what one is willing to do depends on what one thinks one is able to do.

Q Is it your testimony that Mrs. Cipollone was -- when her husband told her to stop smoking and urged her to stop smoking, your testimony is that she was willing to do that? She wanted to respond to her husband?

A No, I didn't say that.

Q She wanted to stop smoking?

A I didn't say that.
Q Was she willing? Did she want to do what he was telling her to do?
A I think some of the times she did.
She reports that it was very hard and that that -- she does that in the context of explaining why she didn't do it.
Q And some of the times she wasn't willing to do what her husband told her to do; is that correct?
MR. DARNELL: With regard to smoking or other items?
Q We're talking about her husband's entreaties and urges to stop smoking. You understand that, don't you?
A Yes, I do.
Q That's what this line of questioning is about.
A I understand.
Q Okay.
A Her -- let me repeat again what I said.
That to some extent one isn't likely to express willingness to take on something that one feels incapable of doing.
Q Okay. When did Mrs. Cipollone --

A And, in fact, some of her reaction to her husband was based on the fact, in my judgment, that what he was asking her to do was something she felt incapable of doing.

Q And that began right in the beginning, 1946 when he started asking her on first dates to stop smoking?

A And, again, I have testified that I think it's progressive and a matter of degree. And indeed she states way back when that she found it hard to stop.

I'm not saying that that was a constant, but I think that was an element even then.

Q Good. You mention that she could not dispassionately evaluate information regarding hazards of smoking.

What do you mean by that?

MR. DARNELL: Off the record.

(Discussion off the record.)

MR. KEARNEY: Let him answer the question.

A I'm not sure that's a two-minute answer, but I'll try.

Q Why don't you give me two minutes of answer.

MR. SIRRIDGE: You have four minutes by

my watch.

THE WITNESS: You'll cut me off.

MR. DARNELL: Maybe it's not a four-minute answer.

A I mean that one's ability to dispassionately weigh information about one's own behavior depends in part on things like the degree to which one feels one can control the behavior.

That, for example, specifically one's perception of a health risk to one's self may depend in part, not completely, on how much -- to the extent to which you feel you have control over this behavior.

Q How much have you been paid since you were first contacted by Mr. Darnell for your work for Mr. Darnell or Mr. Edell's firm?

MR. DARNELL: In this case?

Q I'm talking about Haines; I'm talking in Cipollone; I'm talking in anything that you've worked at the moment.

A I don't have an exact figure. I'm terrible at billing.

But I think it's a reasonable ballpark to say about $12,000. I'm counting, by the way, today.

Q Pardon?

A I'm counting today.

MR. DARNELL: We're not paying for that, they are.

Q What do you charge?

A Currently I charge $150 an hour or $1500 a day, and twice that for deposition and testimony.

Q Do you have any bills or any time for which you have not billed --

A Yes, I do.

Q -- the Darnell or Edell firm?

A Yes, I did. And that's counted in the estimate.

Q That's counted in the estimate?

A Again, let me be clear that I couldn't swear on that to the penny, but I think that's a reasonable estimate.

Q Right. And that includes your work on the Haines and Cipollone case?

A Correct.

MR. KEARNEY: Good. We'll begin -- What time did you say, nine o'clock?

MR. DARNELL: No. Dr. Shiffman, as I told you, had understood it would be ten. He has made a phone consult at nine, which he expects to last a half hour, so let's start at 9:30, 9:35, as close to that as we can.

MR. KEARNEY: Okay.

THE WITNESS: See you tomorrow.

(The deposition is adjourned at 5:00 p.m.)

W I T N E S S C E R T I F I C A T E

I have read the foregoing transcript and do hereby certify that it is a true and accurate transcript of my testimony in the above matter.

SAUL MARK SHIFFMAN, Ph.D.

Sworn and subscribed to before me
this _____ day of _____, 19__

Notary Public

C E R T I F I C A T E

I, DIANA L.R. SENATORE, a Notary Public and Certified Shorthand Reporter of the State of New Jersey, do hereby certify that prior to the commencement of the examination the witness,

SAUL MARK SHIFFMAN

was sworn by me to testify the truth, the whole truth and nothing but the truth.

I DO FURTHER CERTIFY that the foregoing is a true and accurate transcript of the testimony as taken stenographically by and before me at the time and on the date hereinbefore set forth.

I DO FURTHER CERTIFY that I am neither a relative nor employee nor attorney or counsel of any of the parties to this action, and that I am neither a relative nor employee of such attorney or counsel, and that I am not financially interested in the action.

Diana L.R. Senatore

DIANA L.R. SENATORE, C.S.R.
Certificate No. XI01397
Notary Public of New Jersey
My Commission expires October 31, 1994